

FOREMAN, TAMARINE M., Ph.D. A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training. (2015)
Directed by Dr. Kelly L. Wester. 281 pp.

Due to the prevalence of traumatic experiences, and the high percentage of clients who have experienced trauma, it is evident most counselors will encounter clients with a history of trauma (Bride, 2004; Pearlman & Mac Ian, 1995; Sommer & Cox, 2006; Tuma 2013). Counselors who work with clients who have experienced trauma "...risk deep emotional connection, both intrapsychically within themselves, and interpersonally with others" (Saakvitne, 2002, p. 445). As counselors build therapeutic relationships and empathically engage with clients, they open their selves to both the risk of vicarious traumatization and the opportunity for posttraumatic growth. Vicarious traumatization is defined as the "...transformation in the inner experience that comes about as a result of empathic engagement with clients' trauma material" (Pearlman & Saakvitne, 1995, p. 31) and as an enduring psychological consequence of being exposed to traumatic experiences of clients (Schauben & Frazer, 1995). On the other hand, posttraumatic growth encompasses enhanced and improved self-perception, interpersonal relationships, and philosophy of life that occurs as a result of experiencing or witnessing trauma (Arnold, Calhoun, & Tedeschi, 2005; Saakvitne, et al., 1998).

The purpose of this study was to examine vicarious traumatization and posttraumatic growth, explore how each construct is influenced by personal characteristics of the counselor in training, and give voice to counselors in training about their initial experiences within the proximal process as they engage with clients who have been traumatized. The study utilized the constructivist self-development theory and

Bronfenbrenner's (2005) bioecological theory of human development and the process-person-context-time (PPCT) research model as theoretical frameworks to examine vicarious traumatization and posttraumatic growth among counselors in training. An explanatory sequential mixed methods study was implemented and carried out in two phases. The first phase of the study measured vicarious traumatization and posttraumatic growth and examined the influence of empathy, personal trauma history, exposure to clients with a history of trauma, and supervision hours. In phase two, counselors in training were purposefully selected based on their levels of vicarious traumatization and posttraumatic growth. The counselors in training who participated in individual semi-structured interviews assisted in shedding light on the proximal process of counseling clients who have a history of trauma.

In the current study, counselors in training exhibited an average level of vicarious traumatization and a moderate degree of posttraumatic growth that was similar to mental health professionals who had worked in the field for at least 10 years. The combination of empathy and hours of supervision were observed to significantly account for 33% of the variance in vicarious traumatization. The importance of empathy and supervision was also echoed by the voices of counselors in training who participated in phase two of the study. In addition, the counselors in training shared how presence and connection were important elements within the proximal process of counseling. While it is clear that counselors in training exhibit a level of vicarious traumatization and posttraumatic growth, there were inconclusive results as to what significantly contributes to the development of these constructs indicating the need for additional research. Furthermore,

implications for theory, counselor educators, and supervisors gleaned from this study will be shared while taking into consideration relevant literature on vicarious traumatization and posttraumatic growth.

A MIXED METHODS EVALUATION OF VICARIOUS TRAUMATIZATION AND
POSTTRAUMATIC GROWTH AMONG COUNSELORS IN TRAINING

by

Tamarine M. Foreman

A Dissertation Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Greensboro
2015

Approved by

Kelly L. Wester, PhD
Committee Chair

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of the Graduate School at The University of North Carolina at Greensboro.

Committee Chair

Kelly L. Wester, PhD

Committee Members

Christine Murray, PhD

Robert Henson, PhD

Jonathan Tudge, PhD

March 17, 2015
Date of Acceptance by Committee

March 17, 2015
Date of Final Oral Examination

ACKNOWLEDGEMENTS

*Can I see another's woe
And not be in sorrow too?
Can I see another's grief,
And not seek for kind relief?*

*Can I see a falling tear,
And not feel my sorrow's share?*

-William Blake
On Another's Sorrow

My journey has brought me in contact with many extraordinary people and those encounters have influenced and shaped my professional and personal journey. Those that I encountered as clients shared stories and propelled my desire to obtain a degree so that I might teach and train future counselors. In those moments, I was touched by their stories and their willingness to allow me the opportunity to bare witness to their stories and their pain. Their stories have inspired me and touched me deeply.

While at UNCG, I have encountered professionals that inspired me to “show up more” and share more of myself with others. I have been challenged to go deeper in my research and walk around in theory to gain depth and perspective. I have been afforded opportunities to coordinate, supervise, and teach. Professionally, I have presented and obtained research funding from ACES. I possess a genuine expression of gratitude to each of the faculty and all of my committee members for always challenging, supporting, and believing in me.

Another aspect of my journey at UNCG has been the connections I have made with the doctoral students in our community, especially those of my cohort. I will always remember our great adventure and the times we have shared together. Thank you for all of the laughter, support, and encouragement. Without you, I would not be able to say “Mischief Managed!”

Lastly and certainly not least, my dear husband and wonderful daughter – thank you for all of the sacrifices you have made and for joining me on this grand adventure. I love you both dearly and am so grateful for your unending love and support.

As this part of my journey is ending, a new adventure awaits. I look toward this new adventure with curiosity and excitement. I am filled with deep gratitude for all I have learned and the sincere encounters I have had while at UNCG. Thank you.

TABLE OF CONTENTS

	Page
LIST OF TABLES	viii
LIST OF FIGURES	ix
CHAPTER	
I. INTRODUCTION	1
Statement of the Problem	6
Purpose of the Study	9
Significance of the Study	11
Research Questions to be Addressed	14
Definition of Terms	15
Overview	17
II. LITERATURE REVIEW	18
Introduction	18
Theoretical Overview	20
Constructivist Self-Development Theory	20
Bronfenbreener's Bioecological Theory of Human Development & Process-Person-Context-Time (PPCT) Research Model	28
Empathy	40
Counselors In Training	43
Personal Trauma History	46
Exposure to Clients with a Trauma History	52
Supervision	55
Summary	58
III. METHODOLOGY	60
Introduction	60
Explanatory Sequential Mixed Method Design	60
Proximal Process-Person-Context-Time Research Model	62
Research Questions and Hypotheses for Phase 1: Quantitative	64
Research Questions for Phase 2: Qualitative	65

Phase 1: Quantitative Portion	66
Sample and Participant Selection	66
Instrumentation.....	70
Procedures	78
Data Analysis	80
Phase 2: Qualitative Portion	82
Multiple Case Study	82
Sample and Participant Selection	83
Procedures	85
Data Analysis	86
IV. RESULTS	89
Introduction	89
Phase 1: Quantitative Portion	89
Description of Sample	89
Data Analysis	95
Phase 2: Qualitative Portion	106
Description of Sample	106
Data Analysis	113
Summary	150
V. DISCUSSION	151
Introduction	151
Discussion of the Results	151
Implications	169
Implications for Theory	169
Implications for Practice	172
Implications for Future Research	174
Limitations.....	176
Conclusion.....	179
REFERENCES	182
APPENDIX A. INFORMED CONSENT	206
APPENDIX B. INSTRUMENTATION FOR PHASE 1	215
APPENDIX C. INTERVIEW PROTOCOL FOR PHASE 2	229

APPENDIX D. PARTICIPANT RECRUITMENT	234
APPENDIX E. WELLNESS RESOURCES	240
APPENDIX F. IRB APPROVAL LETTER	242
APPENDIX G. PILOT STUDY	243

LIST OF TABLES

	Page
Table 1. Data Analysis Plan for Phase 1: Quantitative Portion	68
Table 2. Data Analysis Plan for Phase 2: Qualitative Portion	88
Table 3. Regional Demographics of Sample in Phase 1	90
Table 4. Gender, Racial/Ethnicity, Relationship Demographics of Sample in Phase 1	90
Table 5. Clinical Internship Setting and Population for Sample in Phase 1	93
Table 6. Caseload Information for the Sample in Phase 1	93
Table 7. Types of Trauma on Caseload for the Sample in Phase 1	94
Table 8. Personal Trauma History for the Sample in Phase 1	95
Table 9. Descriptive Statistics.....	96
Table 10. t-test Analyses Summary for Vicarious Traumatization	100
Table 11. t-test Analyses Summary for Posttraumatic Growth	102
Table 12. Hierarchical Regression Analyses for Vicarious Traumatization.....	104
Table 13. Hierarchical Regression Analyses for Posttraumatic Growth	106
Table 14. Demographics of Counselors in Training in Phase 2	108
Table 15. Explaining Levels of Vicarious Traumatization	115
Table 16. Explaining Levels of Posttraumatic Growth.....	127
Table 17. Themes from Within the Proximal Process	142
Table 18. Baseline Results for the TABS and PTGI-SF.....	263
Table 19. Results for Repeated Administration of the TABS and PTGI-SF	264

LIST OF FIGURES

	Page
Figure 1. Visual Model for the Explanatory Sequential Mixed Methods Design	61
Figure 2. Repeated Administration of the TABS.....	265
Figure 3. Repeated Administration of the PTGI-SF	265

CHAPTER I

INTRODUCTION

Counselors working with clients who have experienced trauma “...risk deep emotional connection, both intrapsychically within themselves, and interpersonally with others” as they build therapeutic relationships (Saakvitne, 2002, p. 445). In building therapeutic relationships with traumatized clients, counselors open their hearts and minds to listening to stories about devastation, tragedy, and betrayal. The trauma that clients experience range from an event, series of events, or set of circumstances experienced by an individual or a group that causes physical and/or psychological stress reactions that is experienced by an individual as physically or emotional harmful, threatening, or overwhelming and has lasting adverse effects on the individual’s physical, social, emotional, or spiritual well-being (Substance Abuse & Mental Health Services Administration, 2012). Through listening to these stories, counselors’ personal beliefs and assumptions about the world and others can be challenged and counselors’ own assumptions about their self, others, and the world can potentially change (Saakvitne & Pearlman, 1996). This type of listening involves empathic engagement, which encompasses the art of listening (Brockhouse, Msetfi, Cohen, & Joseph, 2011) and the ability to connect with clients in a discerning, highly present, and sensitively attuned

manner (Harrison & Westwood, 2009). When empathic engagement with traumatized clients occurs, counselors open themselves to both the risk of vicarious traumatization and the opportunity for posttraumatic growth.

Unlike the constructs of burnout and compassion fatigue that describe the impact on counselors who work with clients who have been traumatized, vicarious traumatization and posttraumatic growth have been conceptualized within the same theoretical framework of the constructivist self-development theory (CSDT) (McCann & Pearlman, 1990b; Saakvitne, Tennen, & Affleck, 1998). According to CSDT, counselors actively interpret their experiences and continuously revise and adapt their assumptions and perceptions of self, others, and the world as a result of their cumulative experience of working with clients who have been traumatized (McCann & Pearlman, 1990b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). CSDT provides a theoretical integrative framework to evaluate the whole person due to the emphasis on both the negative changes that occur in the aftermath of being exposed to a traumatic experience and the positive changes that occur as a result of the process of making meaning and adaptation (Saakvitne et al., 1998).

Both vicarious traumatization and posttraumatic growth involve an internal transformation of how counselors perceive their self, others, and the world. Vicarious traumatization is defined as the "...transformation in the inner experience that comes about as a result of empathic engagement with clients' trauma material" (Pearlman & Saakvitne, 1995, p. 31) and as an enduring psychological consequence of being exposed to traumatic experiences of clients (Schauben & Frazer, 1995). On the other hand,

posttraumatic growth encompasses the positive changes in self-perception, interpersonal relationships, and philosophy of life that occurs as a result of experiencing or witnessing trauma (Arnold, Calhoun, & Tedeschi, 2005; Saakvitne et al., 1998). The pain and growth resulting from trauma have been described as inextricably linked (Saakvitne et al., 1998). When counselors bear witness to clients' pain, there is also the possibility to witness clients' resilience and healing (Saakvitne & Pearlman, 1996). Researchers have suggested that positive and negative changes in counselors coexist when they empathically engage with clients who have experienced trauma, suggesting that vicarious traumatization and posttraumatic growth are distinct constructs and not mere opposites on the same continuum (Linley, Joseph, Cooper, Harris, & Meyer, 2003).

Despite the suggestions and theoretical conceptualizations, researchers have not empirically evaluated the relationship between vicarious traumatization and posttraumatic growth. It is still empirically unknown how vicarious traumatization and posttraumatic growth are related and if or how one influences the other. In evaluating vicarious traumatization and posttraumatic growth as distinct yet related constructs, a better understanding of how these constructs emerge and change when counselor or counselors in training empathically engage with clients who have experienced trauma can be illuminated. In addition when taken together, vicarious traumatization and posttraumatic growth provide a way to holistically evaluate how counselors and counselors in training are impacted by their work with clients who have experienced trauma.

Although CSDT has been utilized to describe the perceptual and cognitive shifts that occur as a result of counselors working with clients who have experienced trauma, the theory fails to provide a thorough view of the intimate interactional and developmental process of vicarious traumatization and posttraumatic growth that occurs in the context of the therapeutic relationship. CSDT outlines the transformational changes in how a person views and interprets experiences; the ability to experience and tolerate strong emotions; the capacity to relate to others; the need to feel safe, valued, and connected to others; and the management of intrusive thoughts and images (McCann & Pearlman, 1990b; Saakvitne & Pearlman, 1996). However, CSDT does not provide a description of how counselors experience working with traumatized clients within the context of the therapeutic relationship. To further understand the development of vicarious traumatization and posttraumatic growth, it is helpful to utilize Bronfenbrenner's (2005) bioecological theory of human development and the process-person-context-time (PPCT) research model. According to Bronfenbrenner, development occurs within proximal processes that include reciprocal interactions that happen within and across systems or environments, and time (Bronfenbrenner, 2005; Bronfenbrenner & Morris, 2006). From a counseling perspective, the proximal process involves reciprocal interactions between counselor and client that occur in and across counseling sessions that impact the development of counselor, client, and the therapeutic relationship. When counselors engage with clients and the clients' trauma material within the proximal process of counseling, counselors can become vulnerable to vicarious traumatization as well as open their selves to the opportunity for posttraumatic growth. In examining

vicarious traumatization and posttraumatic growth through the lens of the PPCT research model, a better understanding of how these constructs evolve and are influenced by the proximal process within the context of counseling can emerge.

Ethically, it is crucial that vicarious traumatization be addressed (Harrison & Westwood, 2009; Saakvitne & Pearlman, 1996; Sommer, 2008). Trippany, Wilcoxon, and Satcher (2003) described vicarious traumatization as a pervasive condition that leads to counselor distress. Counselors who work with trauma are more vulnerable to developing symptoms of countertransference and vicarious traumatization (Williams, Helm, & Clemens, 2012). Symptoms of distress include cynicism (Etherington, 2000; Saakvitne & Pearlman, 1996; Schauben & Frazier, 1995), social withdrawal (Saakvitne & Pearlman, 1996), sleep disturbances such as nightmares or insomnia (Adams, Matto, & Harrington, 2001; Baird & Jenkins, 2003; Saakvitne & Pearlman, 1996), disturbing images (Adams et al., 2001; McCann & Pearlman, 1990b), anxiety, and depression (Pearlman & Saakvitne, 1995). These symptoms of distress impair the counselor, inhibit the therapeutic relationship, threaten counselor well-being, and hinder the professional obligation of counselors to do no harm.

In moving the conversation forward to describe how counselors are impacted when empathically engaging with clients who have been traumatized, it is important both vicarious traumatization and posttraumatic growth will be evaluated within the proximal process of counseling. In addition, the voices of counselors in training need to be incorporated to provide an initial in-depth view of the proximal process of counseling clients who are traumatized. Counselors in training are poised to provide an

understanding about the initial accumulation of exposure to clients' trauma material and the beginning development of vicarious traumatization and posttraumatic growth because they are at the beginning of their professional training. Novice counselors often have exaggerated expectations of the counseling process, which elevates the risk for additional stressors and shifts in beliefs about their self as competent (Skovholt & Ronnestad, 2003). The inclusion of counselors in training and exploring the initial exposure to traumatized clients within the proximal process provides an opportunity to expand the understanding of how vicarious traumatization and posttraumatic growth develop.

Statement of the Problem

According to Tuma's (2013) presentation to the National Advisory Mental Health Council at the National Institute of Mental Health, nearly 8 million people are believed to struggle with post-traumatic stress disorder on any given day. In addition, Bride (2004) described 82 to 94 percent of clients seeking assistance at community mental health agencies as having a history of a traumatic experience. Due to the prevalence of traumatic experiences, and the high percentage of clients who have experienced trauma, it is evident most counselors will encounter clients with a history of trauma, increasing their risk for developing vicarious traumatization (Bride, 2004; Pearlman & Mac Ian, 1995; Sommer & Cox, 2006; Tuma, 2013). Based on this information, it is imperative counselors be made aware of and be prepared for the possibility of vicarious traumatization and understand how to take steps toward developing posttraumatic growth. Counselors who are aware of how vicarious traumatization develops will be

better prepared to recognize impairment and more fully appreciate the need for self-care strategies that foster posttraumatic growth.

In order to broaden our knowledge about the influence of the proximal process on vicarious traumatization and posttraumatic growth, it is necessary to examine more closely the interactions within the therapeutic relationship between counselors and clients who have experienced trauma. Researchers who have explored vicarious traumatization and posttraumatic growth have not provided a thorough description of the intimate interactions involved in the proximal process of counseling as counselors engage with clients who have experienced trauma. Thus, although researchers have shown that vicarious traumatization and posttraumatic growth are related to the counselor's empathic engagement with traumatized clients (Brockhouse et al., 2011; Harrison & Westwood, 2009; Jordan, 2010; Linley & Joseph, 2007), it is unknown what aspects of the proximal process impact counselors. The application of Bronfenbrenner's (2005) bioecological theory of human development and the process-person-context-time (PPCT) research model provides a way to more fully understand how counselors are impacted when working with clients who have been traumatized. The PPCT research model includes an evaluation of the proximal process, person characteristics, context or environment, and elements of time that impact the therapeutic relationship (Bronfenbrenner, 2005; Bronfenbrenner & Morris, 2005). Bronfenbrenner's (2005) bioecological theory of human development and the PPCT research model provides the framework to more fully explore, understand, and contextualize the proximal process and the development of

vicarious traumatization and posttraumatic growth in counselors working with clients who have experienced trauma.

Further, researchers have neglected to include the experiences of counselors in training when evaluating the impact of working with clients who have been traumatized. Counselors in training are tasked with translating information from textbooks into the practice of counseling while at the same time trying to manage boundaries and regulate their own emotions, specifically fear and anxiety, during counseling sessions (Skovholt & Ronnestad, 2003). This places counselors in training at risk for developing vicarious traumatization because it is their initial exposure to counseling clients with a history of traumatic experiences. Researchers have primarily conducted studies exploring vicarious traumatization and posttraumatic growth have been obtained primarily from quantitative and cross-sectional methods with counselors who have more than five years of experience (Arnold et al., 2005; Benatar, 2000; Bober & Regehr, 2006; Bourassa, 2012; Branson, Weigand, & Keller, 2013; Brockhouse et al., 2011; Cunningham, 2003; Devilly et al., 2009; Harrison & Westwood, 2009; Linley & Joseph, 2007; Parker & Henfield, 2012; Pearlman & Mac Ian, 1995; Williams, Helm, & Clemens, 2012). Pearlman and Mac Ian (1995) suggested future research include counselors with two or less years of experience to determine and better understand the level and development of vicarious traumatization in this population but this has not been done.

When novice counselors have been evaluated, their responses have been included in the aggregate data without being differentiated from seasoned counselors (Baker, 2012; Brady, Guy, Poelstra, & Brokaw, 1999; Culver, McKinney, & Paradise, 2011;

Devilly et al., 2009; Linley & Joseph, 2007; Pearlman & Mac Ian, 1995; Williams et al., 2012). One qualitative study, conducted by Hunter (2012), included ten participants of which only two had less than two years of experience. Hunter (2012) noted that the two less experienced therapists had more difficulty than the eight more experienced therapists working with clients who had been sexually assaulted. One of the less experienced therapists in Hunter's (2012) study stated she once told her co-worker that "...there is no God" (p. 185) and that she was unable to be intimate with her "...partner because all day [she] hear[s] what is done to children" (p. 186). Clearly, the voices of counselors with less than two years of experience are needed to further understand the proximal process of counseling with clients who have experienced trauma. The inclusion of voices belonging to counselors in training will fill a gap that enables a better understanding of the educational, training, supervision, and supportive needs counselors in training require as they begin to empathically engage with clients who have experienced trauma.

Purpose of the Study

The purpose of this study is to examine vicarious traumatization and posttraumatic growth, explore how each construct is influenced by personal characteristics of the counselor in training, and give voice to counselors in training about their initial experiences within the proximal process as they engage with clients who have been traumatized. The results from this study will provide information on how to support developing counselors' longevity in the field by highlighting information about the proximal process of providing counseling to clients who have experienced trauma and the impact on counselors in training, as well as give a greater understanding to how vicarious

trauma and posttraumatic growth are influenced by the personal characteristics of empathy, personal trauma history, exposure to clients with a history of trauma, and the amount of time spent in supervision. To achieve this, an explanatory sequential mixed methods study will be implemented, which will be carried out in two phases. The first phase of the study will measure vicarious traumatization and posttraumatic growth and examine the influence of empathy, personal trauma history, exposure to clients with a history of trauma, and supervision hours. In phase two, counselors in training will be purposefully selected based on their scores on vicarious traumatization and posttraumatic growth. The selected counselors in training for phase two will participate in individual semi-structured interviews aimed at examining the proximal process and providing depth to the observed scores of vicarious traumatization and posttraumatic growth. The responses from the semi-structured individual interviews will be analyzed using case study methodology to highlight the voices of counselors in training and the common themes that emerge from answers relating to the proximal process of engaging with clients who have experienced trauma. Further, the counselors in training will have the opportunity to share their personal reflections about their observed scores on the standardized measures during interviews. In this way, the results of the selected participants' scores obtained on standardized measures of vicarious traumatization and posttraumatic growth will be explained and corroborated by participants' own voices, giving insight into the proximal process of working with traumatized clients. In addition, the voices of counselors in training will provide information on how the initial exposure to working with clients who have experienced trauma impacts the counselor's beliefs and

assumptions of their self, others, and the world. The implementation of a mixed methods study will better illuminate the dimensions of vicarious traumatization and posttraumatic growth along with the proximal process of the client and counselor relationship, which would not have been able to be discovered utilizing only one methodology (Ben-Porat & Itzhaky, 2009).

Significance of the Study

Counselors are entrusted with the facilitation and promotion of their clients' well-being, which are guided by ethical codes. The American Counseling Association's (ACA) 2014, ethical codes describe counselors as being responsible for monitoring their own effectiveness and signs of impairment (ACA, 2014, C2.d., & C.2.g.). Vicarious traumatization is a form of impairment in which the stories clients share about traumatic experiences become traumatic stressors for counselors (Harrison & Westwood, 2009). The symptoms of vicarious traumatization include cynicism, social withdrawal, nightmares, and increased sensitivity to violence that result in changes to how counselors view themselves as capable, others as safe, and the world as fair and just (Adams et al., 2001; Baird & Jenkins, 2003; Etherington, 2000; Saakvitne & Pearlman, 1996; Schauben & Frazier, 1995). Therefore, it is an ethical imperative to educate counselors about the possibility of vicarious traumatization and how it can impair a counselors' ability to effectively work with clients. In order to educate counselors, a better understanding is needed of how aspects of the proximal process within the therapeutic relationship, both during and between sessions, influence the development of vicarious traumatization and facilitates posttraumatic growth.

In addition, counselors should be made aware of the opportunity for posttraumatic growth and how that growth can be facilitated through awareness, self-care, and supervision (Harrison & Westwood, 2009; Lambert & Lawson, 2013; Linley & Joseph, 2007; Trippany, Kress, & Wilcoxon, 2004). Counselors need a better understanding of how posttraumatic growth relates to experiences of vicarious traumatization and how working with traumatized clients can lead to posttraumatic growth. The potential outcomes of posttraumatic growth include more positive satisfaction in interpersonal relationships (Hernandez, Engstrom, & Gangsei, 2010; Joseph, 2009), having a greater appreciation for life (Hernandez et al., 2010; Joseph, 2009), and higher levels of empathy (Brockhouse et al., 2011; McCann & Pearlman, 1995). This furthermore supports the ethical obligation for counselors to recognize impairment and do no harm.

Ethical codes also require supervisors to ensure client welfare, assess supervisee performance (ACA, 2014, F.1.a.), and endorse only those supervisees who are not impaired (ACA, 2014, F.6.d.). Researchers who have conducted studies on counselors who provide services to clients who have experienced trauma report that supervision, regardless of license and years of experience, is helpful in decreasing vicarious traumatization and facilitating posttraumatic growth (Bell, Kulkarni, & Dalton, 2003; Brockhouse et al., 2011; Harrison & Westwood, 2009; Linley & Joseph, 2007; Pearlman & Mac Ian, 1995; Sommer 2008). Providing supervisors with information about the symptoms of vicarious traumatization will assist supervisors in recognizing when a counselor or counselor in training has been negatively impacted or is impaired. In addition, the voices of counselors in training will provide information on how supervisors

can best support counselor development, well-being, and foster posttraumatic growth. Supervision can assist in minimizing the risk of harm to clients (Harrison & Westwood, 2009), aid in healing from vicarious traumatization, and facilitate posttraumatic growth (Bell et al., 2003).

Counselor educators are also ethically obligated to evaluate student performance (ACA, 2014, F.9.a.) and address any concerns that might impede a counselor's professional performance (ACA, 2014, F.8.d.). Evaluating the initial experiences of counselors in training as they begin to engage empathically with clients who have been traumatized will illuminate how to best educate, train, and support the professional development of counselors. In addition, information can be gleaned about what counselors in training need during their education to assist in preparing them to work with clients who have been traumatized. Counselor educators could then teach counselors in training how to monitor themselves for symptoms of vicarious traumatization and support the development of long-term self-care strategies. When counselor educators inform counselors in training about the potential to develop vicarious traumatization and posttraumatic growth, counselors will be forewarned, forearmed, and more prepared to enter and remain in the profession (Walker, 2004).

According to the ethical codes, counselors, supervisors, and counselor educators are obligated to understand the nature and impact of the proximal process when working with clients who have been traumatized. In order to meet these guidelines, it is imperative that counselors, supervisors, and counselor educators understand the development of vicarious traumatization and posttraumatic growth. By illuminating the

process of vicarious traumatization and posttraumatic growth, implications for education, training, and support will be gleaned for counselors, supervisors, and counselor educators.

Research Questions to be Addressed

The following research questions have been developed based on the research literature and will be a guide for this explanatory sequential mixed methods study:

Research Question 1: What are the levels of vicarious traumatization and posttraumatic growth among counselors in training?

Research Question 2: Are the levels of vicarious traumatization and posttraumatic growth among counselors in training significantly differentiated by personal trauma history, amount of exposure to client trauma, and number of supervision hours?

Research Question 3: How do empathy and person characteristics found to be significant in research question two (i.e. personal trauma history, exposure to clients with trauma, hours of supervision) influence levels of vicarious traumatization and posttraumatic growth among counselors in training?

Research Question 4: How do counselors in training explain their observed scores on the standardized measurements for vicarious traumatization and posttraumatic growth?

Research Question 5: How do counselors in training describe their experiences within the proximal process of providing counseling services to clients who have experienced trauma?

Definition of Terms

For the purposes of this study, the following definitions were used to operationalize key constructs and concepts.

Trauma is defined as an event, series of events, or set of circumstances experienced by an individual or a group that causes physical and/or psychological stress reactions that is experienced by an individual as physically or emotionally harmful, threatening, or overwhelming and has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being (Substance Abuse & Mental Health Services Administration, 2012).

Vicarious traumatization is the transformation that occurs within the inner experience of the counselor as a result of empathic engagement with clients who have experienced trauma and exposure to the client's trauma material (Pearlman & Saakvitne, 1995a; Saakvitne et al., 1998). Vicarious traumatization not only encompasses a counselor's change in view of their self as competent, but also more negative shifts and perceptions of the self as less capable, others as untrustworthy, and the world as an unsafe place. For the purposes of this study, vicarious traumatization will be measured utilizing the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003).

Posttraumatic growth encompasses improvements and enhancements in the counselor's self-perception, interpersonal relationships, spiritual well-being, and philosophy of life as a direct result of working with client's trauma material (Arnold, Calhoun, & Tedeschi, 2005; Saakvitne et al., 1998). The changes include a counselor's perception of their self as more capable, an enhanced appreciation of interpersonal

relationships with others, and a deepening of spiritual connectedness to the world and others. For the purposes of this study, posttraumatic growth will be measured utilizing the Posttraumatic Growth Inventory-Short Form (PTGI-SF; Cann et al., 2010).

Proximal Process is an enduring interaction that occurs in a person's immediate environment, as well as across time, and is a driving engine for development (Bronfenbrenner, 2005). Counseling is a proximal process in which the counselor and client interact. As a proximal process, counseling incorporates reciprocal interactions during which counselors build rapport, evaluate client competence in the present, recognize the influence of history and societal expectations on client development, and provide opportunity for the client to engage in new ways of interaction to support development of new skills. The researcher will utilize questions during the semi-structured interviews with counselors in training to learn more about the proximal process.

Empathic engagement involves the application of empathy in the client-counselor relationship. Empathy involves the art of understanding and includes the cognitive ability to understand the client's inner experiences and perspectives as well as the capability of the counselor to communicate this understanding (Brockhouse et al., 2011; Hojat, 2007). Empathy is the counselor's ability to "...sense the client's private world as if it were [their] own" (Rogers, 1957, p. 99). Empathy is a multidimensional concept that entails perspective taking, compassionate care, and the ability to stand in the client's shoes (Hojat, et al., 2002; Hojat, 2007). For the purposes of this study, empathy

will be measured utilizing the Jefferson Scale of Empathy for Health Professions Students (JSE-HP-S; Fields et al., 2011)

Overview

The researcher will present this study in five chapters. In the first chapter, presented above, addressed the need, purpose, and significance of the study. Chapter I also outlined the guiding research questions and reviewed operational definitions of the key constructs and concepts that will be explored in this study. In the second chapter, the researcher will review and critique the research literature relevant to how counselors have been described as being impacted by their work with clients who have experienced trauma. In addition, Chapter II will provide a thorough description of the guiding theoretical and conceptual framework for this study. The methodology chapter, Chapter III, will highlight the explanatory sequential mixed methods of the study. Chapter III will include the research questions, hypotheses, selection of participants, instrumentation, procedures, and data analysis plans for both phases of the study. Chapter IV will present the results of the data analyses related to specified research questions for each phase. The final chapter, Chapter V, will discuss and integrate the results of the study, address limitations, and provide implications for counselor education, counselor training, and future research.

CHAPTER II

LITERATURE REVIEW

Introduction

The study of vicarious traumatization began in the 1990's, when McCann and Pearlman, along with Saakvitne and the staff at The Traumatic Stress Institute in Connecticut began exploring and sharing how they were being impacted by the work they were doing with clients who had a history of trauma. The Traumatic Stress Institute was a specialized treatment center for providing services to clients with traumatic experiences. During the process of providing these services, McCann, Pearlman, and Saakvitne became aware that, as trauma therapists, they were sharing similar signs and symptoms as a result of working with trauma. Those symptoms included a shift in how counselors saw their selves as competent and effective, others as trustworthy, and the world as a safe place. The authors stated, "having chosen these careers, [they] will never again be the same" (Saakvitne & Pearlman, 1996, p. 17). This became the foundation for the development of vicarious traumatization and the constructivist self-development theory.

According to McCann and Pearlman (1990) "vicarious traumatization can be understood as related both to the graphic and painful material trauma clients often present to the therapist's unique cognitive schemas or beliefs, expectations, and assumptions

about self and others” (p. 131). A later description offered by Pearlman and Saakvitne (1995) described vicarious traumatization as the “...transformation in the inner experience that comes about as a result of empathic engagement with clients’ trauma material” (p. 31). In addition, McCann and Pearlman (1990) described the experience of vicarious traumatization as an inevitable consequence of working with clients who have a history of trauma. It is when vicarious traumatization is unacknowledged and remains unknown to the counselor or counselor in training that the symptoms become overwhelming and have the potential to harm the therapeutic relationship and threaten the ethical obligation to do no harm.

Another aspect to treating clients with trauma that has been researched is posttraumatic growth. Posttraumatic growth developed as a result of Tedeschi and Calhoun’s awareness that people who had experienced a traumatic event also reported positive changes as a result of the traumatic event (Calhoun & Tedeschi, 1999, 2004).

According to Tedeschi and Calhoun (2004), posttraumatic growth encompasses the

...experience of positive change that occurs as a result of the struggle with highly challenging life crises. ... [that is] manifested in a variety of ways, including an increased appreciation for life in general, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life. (p. 1).

McCann and Pearlman (1990) also noted positive effects from working with clients who have a history of trauma that included increased empathy and deeper connection to others. Later other researchers applied posttraumatic growth in their research with experienced therapists who worked with trauma (Brockhouse, Msetfi, Cohen & Stephen

2011; Linley & Joseph, 2007). As counselors in training are exposed to clients who have a trauma history, it is possible that counselors in training might also experience posttraumatic growth.

Research conducted on how counselors are impacted by client trauma narratives provides conflicting information as to what contributes to the development of vicarious traumatization and posttraumatic growth. In addition, the evaluation of how counselors in training experience vicarious traumatization and posttraumatic growth is absent from the research literature. The following paragraphs will explore the research literature on personal trauma history, exposure to clients with a trauma history, and supervision framed from the perspective of vicarious traumatization and posttraumatic growth. The relevant research literature on counselors in training and empathy will also be reviewed. In addition the theoretical frameworks of constructivist self-development theory and Bronfenbrenner's bioecological theory of human development will be explored and evaluated as contributing to the understanding of vicarious traumatization and posttraumatic growth. The section will conclude with a summarization of the information obtained from the review of relevant literature and review the purpose of the study.

Theoretical Overview

Constructivist Self-Development Theory

In order to better understand vicarious traumatization and posttraumatic growth, it is important to explore how the experience of trauma can impact counselors in training. The constructivist self-development theory (CSDT) offers a lens with which to view how

trauma potentially impacts the counselor in training. McCann and Pearlman (1990) developed CSDT as a framework for understanding the psychological effects of working with clients who have a history of trauma. The theory emphasizes adaption and integrates aspects from other theories such as psychoanalytic, interpersonal psychology, social learning, and cognitive theory (McCann & Pearlman 1990a; 1990b; Pearlman, 1997; Saakvitne & Pearlman, 1996). According to CSDT, the impact of working with trauma is unique to each counselor and results from the interaction of aspects of the client's trauma material along with aspects of the counselor's own psychological needs and resources (Pearlman, 1996). The theory considers vicarious traumatization and posttraumatic growth as a process that occurs over time as a result of exposure to client trauma narratives and has the potential to disrupt the counselor's way of seeing the world.

The areas of the self that are potentially disrupted are considered core areas. The core areas include a person's frame of reference, self-capacities, ego resources, psychological needs and cognitive schemas, and memories and perceptions (McCann & Pearlman, 1990a; 1990b; Saakvitne & Pearlman, 1996). These core areas of the self are both experiential and cognitive approaches utilized to organize and understand experiences (Saakvitne et al., 1998).

Frame of Reference. The frame of reference refers to how a person understands and perceives self and the world (Saakvitne et al., 1998). It is the framework with which one's beliefs are used to interpret one's experiences, including the assigning of causality and attribution (Saakvitne & Pearlman, 1996; Trippany et al., 2004). The frame of reference framework includes identity, worldview, and spirituality. Identity refers to

one's internal processes and experiences of being with others and being in the world (Saakvitne & Pearlman, 1996). For the counselor in training, this includes professional identity as a counselor and how personal and professional experiences shape this perception. Supervision could be an important part of the counselor in training's developing view of self as an effective and qualified professional counselor. The worldview includes one's general perceptions about others and the world, while spirituality refers to one's meaning and connection to aspects of others and the world (Saakvitne & Pearlman, 1996). The worldview and spirituality frames of reference influence the counselor in training's understanding of the therapeutic relationship. For counselors in training who experience a disruption to their frame of reference, they might view or place blame on the client who has experienced the traumatic event rather than viewing the client as blameless (Trippany et al., 2004).

Self-Capacities. The self-capacities assist in regulating self-esteem. Self-capacities includes the ability to regulate strong emotions, and maintain a consistent and coherent sense of self (McCann & Pearlman, 1990b; Trippany et al., 2004). In addition, self-capacities include the ability to recognize, tolerate, and integrate affect while also sustaining positive feelings toward one's self, and maintaining relationships with others (Saakvitne et al., 1998; Trippany et al., 2004). When the need for self-capacities is balanced, the counselor in training is better able to tolerate emotional and cognitive ambiguity (Pearlman, 1997). Counselors in training with a disruption in their self-capacities might doubt their competence and the ability to provide effective counseling services, or may have difficulty managing strong emotional responses to a client's trauma

material. Trippany, Kress, and Wilcoxon (2004) suggested counselors might also experience a loss of identity, avoid any media that conveys trauma material similar to that of clients, and have difficulty meeting the needs of significant others. Thus, the client trauma narrative reverberates and remains with the counselor in training beyond the counseling session and impacts the professional and personal life of the counselor in training.

Ego Resources. Ego resources assist the counselor in accessing and maintaining their own psychological needs, while also assisting in regulating interactions with others (McCann & Pearlman, 1990b; Pearlman, 1997). The ego resources include empathy, intelligence, the ability to strive for personal growth, foresee consequences, and the ability to establish boundaries (McCann & Pearlman, 1990b). When ego resources are disrupted, the counselor in training may work too many hours or work overtime, have difficulty empathically engaging with clients, and may experience an increased need for perfectionism (Trippany et al., 2004). The difficulty in setting and maintaining boundaries and decreased empathic ability has the potential to create ethical dilemmas for counselors in training (Trippany et al., 2004). As one sexual abuse counselor stated, “Her (the client’s) situation seemed so desperate that I became more and more involved. I gave her my home phone number and accepted calls at anytime.” (Richardson, 2001). When ego resources are disrupted the potential for counselors in training to have difficulty maintaining professional boundaries and abide by best clinical practices is jeopardized.

Psychological Needs and Cognitive Schema. The psychological needs are viewed as internally motivating an individual’s own behavior and includes safety,

esteem, trust and dependency, control, and intimacy (McCann & Pearlman, 1990a, 1990b; Saakvitne & Pearlman, 1996). Cognitive schemas are also important when discussing psychological needs, as the schemas are a person's internal organizational framework for perception of self, others, and the world (McCann & Pearlman, 1990b). Each psychological need influences the cognitive schemas of the counselor and the counselor's development. The disruption to these needs can be subtle or shocking depending on the discrepancy between the client's trauma narrative and the counselor's existing beliefs (McCann & Pearlman, 1990b).

Safety. Safety is defined as the counselor's need to feel safe and the ability to operate in the world without fear of harm (McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995). When a sense of safety is disrupted, the counselor in training may have difficulty feeling safe from real or imagined threats and worry about the safety of others (McCann & Pearlman, 1990b; Trippany et al., 2004). Counselors in training might experience a heightened sense of awareness of vulnerability and increased awareness about the fragility of life (McCann & Pearlman, 1990b). However, on the other hand, recognition of one's vulnerability may also increase emotional expressiveness and greater utilization of social support (Tedeschi, 1999).

Esteem. The psychological need of esteem is related to one's ability to feel valued and the ability to value others (Pearlman, 1995; Pearlman & McCann, 1990b; Saakvitne & Pearlman, 1996). Esteem also involves a benevolent belief in others and their worthiness of respect (McCann & Pearlman, 1990b). When listening to client's trauma material, the need of esteem is threatened as a result of being exposed to stories

that characterize others as cruel and the world as unfair (Trippany et al., 2004).

Counselors in training whose esteem is disrupted might begin to feel hopeless and doubt their ability to help clients. However, when esteem is enhanced by working with clients who have a history of trauma, the counselor in training might feel empowered. For example, one participant in Benatar's (2000) qualitative study with trauma therapists shared that "Working with survivors enhances my self-esteem and is thereby emotionally satisfying. Empowering my survivor clients empowers me" (p. 19).

Trust/dependency. Trust or dependency involves trusting one's own judgment and a belief that others are reliable (Pearlman & Mac Ian, 1995). Trippany and colleagues (2004) described the repeated exposure to client trauma material as potentially shaking a person's foundations of trust with others and themselves. According to CSDT, every person has an inherent need to trust their self and others (Trippany et al., 2004). However, when trust with one's self or others are disrupted, the counselor in training might become less trusting of others, more cynical, and more suspicious or skeptical about the intentions of others (McCann & Pearlman, 1990b). When relating to one's self without trust, there is a tendency for more self-doubt and less confidence in one's abilities to provide effective counseling services. When a participant in Benatar's (2000) qualitative study with 12 trauma therapists, were asked about worldview, one participant responded, "How do you live in a world where horrible things happen? How do you make peace with this? How do you forgive?" (p. 15).

Control. The description of control is similar to locus of control and the belief one has about their ability to control what happens to them or others (McCann &

Pearlman, 1990b). When the need for control is disrupted and out of balance, the counselor in training might exhibit over controlling or helplessness behaviors (Trippany et al., 2004). This might also lead to a sense of disparity about the uncontrollable and unpredictable forces of nature or human violence (McCann & Pearlman, 1990b).

Intimacy. The psychological need of intimacy is related to feeling connected to oneself and others (McCann & Pearlman, 1990a). Without intimacy, counselors in training might feel isolated and lonely. According to Pearlman (1995), when intimacy is disrupted the counselor might experience feelings of emptiness, loneliness, and have difficulty feeling joy. As a result, a counselor in training might have an intense need to fill alone time and become overly dependent or become avoidant of others and withdrawal (Pearlman, 1995). Branson, Weigand, and Keller (2013) reported a small, yet significant inverse relationship between vicarious trauma and level of sexual desire among behavioral health clinicians working with clients.

Memories and Perceptions. The final element in CSDT involves a person's perceptual and memory systems and include the visual relationship to the trauma narratives a counselor hears (McCann & Pearlman, 1990b). Pearlman and Saakvitne (1995) identified five areas of the memory system that are involved with processing client trauma material. Those areas include verbal or cognitive memory, imagery, affect, bodily or physical sensations, and interpersonal memory (Pearlman & Saakvitne, 1995). A person whose perceptual and memory systems have been affected may experience flashbacks, nightmares, or reoccurring dreams about the event or events they have heard (McCann & Pearlman, 1990b; Saakvitne & Pearlman, 1996). When the memory and

perceptual system is disrupted or overwhelmed, the counselor in training might implement numbing, avoidance, or denial strategies (Trippany et al., 2004), which may lead to professional and personal impairment.

CSDT has been evaluated in conjunction with vicarious traumatization within conceptual articles (e.g. Dunkley & Whelan, 2006; Saakvitne et al., 1998; Trippany et al., 2004), quantitative studies (e.g.; Pearlman & Mac Ian, 1995; Schauben & Frazer, 1995; Williams, Helm, & Clemens, 2012), and qualitative studies (e.g. Baker, 2012; Benatar, 2000; Harrison & Westwood, 2009). These studies, either through utilization of the Trauma and Attachment Beliefs Scale (TABS; Pearlman, 2003) or interviews, explored the effect of trauma from the framework of CSDT, especially in relation to the psychological needs and cognitive schemas. CSDT also assists in understanding posttraumatic growth as the theory emphasizes adaptation and the process of making meaning. Calhoun, Cann, Tedeschi, and McMillan (2000) described posttraumatic growth as more likely to develop when one spends time thinking about the traumatic event and attempts to make meaning of the experience. CSDT provides an integrative context to evaluate the whole person of the counselor in training, emphasizes adaptation, and differentiates aspects of the self that can be affected by working with trauma (Saakvitne, Tennen, & Affleck, 1998). When vicarious traumatization and posttraumatic growth are viewed from the lens of CSDT, a more holistic understanding about how a counselor in training might be impacted through their empathic engagement with clients is gained.

Although CSDT conceptually recognizes the unique interplay of the aspects of the client's trauma material with aspects of the counselor's own psychological needs and resources (Pearlman, 1996), the theory fails to explore the intimate and reciprocal interactions between the counselor in training and the client's trauma narrative. In addition, CSDT does not adequately explore or explain person characteristics beyond the core aspects of self and does not consider the contextual influences of the counselor in training's environment. In order to deepen the understanding of the intimate and reciprocal interactions between the counselor in training and client and further the understanding of vicarious traumatization and posttraumatic growth the process, person, context, time research model proposed within Bronfenbrenner's bioecological theory of human development was also employed as a theoretical framework for this study.

Bronfenbrenner's Bioecological Theory of Human Development & Process-Person-Context-Time (PPCT) Research Model

Bioecological Theory of Human Development. According to Bronfenbrenner (2005), the bioecological theory of human development involves the evaluation of the "...continuity and change in the biopsychological characteristics of human beings, both as individuals and as groups" across their lifespan (p. 3). Bronfenbrenner viewed a person's development as driven by proximal processes within and across various environments or contextual systems across a person's lifespan. Although much of the research has been confined to the context and ecological systems, Bronfenbrenner's later theoretical model moved toward a more comprehensive evaluation of human development. The movement towards the center of his model provides a close

examination of the individual and the processes in which the individual interacts. The most important aspect impacting development was the proximal processes in which the person interacts in and across time and contexts.

Bronfenbrenner was interested in how a person experiences his or her environment from the person's objective and subjective perceptions. These perceptions shape a person's development but each element does not occur in isolation. The mature form of the bioecological theory of human development included these perceptions along with elements of the proximal process, person characteristics, context, and time to more fully describe human development.

Proximal Process. Bronfenbrenner utilized the perception of a person's objective and subjective experiences to examine the interactions that shape development within proximal processes. According to Bronfenbrenner (1977), interactions were considered the main effects and focus of ecological research. As ecological theory evolved into the bioecological theory, proximal processes became the focus of investigation. A proximal process is an enduring interaction that occurs in a person's immediate environment, across time, and is a driving engine for development (Bronfenbrenner, 2005). These interactions are reciprocal and involve interpersonal connections that occur within and across systems or environments, and time (Bronfenbrenner & Morris, 2006). The power of the proximal process varies depending on characteristics of the individual, the environment, and the developmental outcome (Bronfenbrenner & Morris, 2006).

Central to the proximal processes are two propositions, which outline the presence of these reciprocal interactions. The first proposition, as described by Bronfenbrenner (1995) described human development as occurring through progressively more complex processes between the person and other persons, objects, or symbols within the person's immediate environment (Bronfenbrenner, 1995; Bronfenbrenner & Morris, 2006). The proximal processes were described as effectively impacting development when they occur on a regular basis over extended periods of time (Bronfenbrenner, 1995; Bronfenbrenner & Morris, 2006). In the second proposition, Bronfenbrenner (1995) outlined the interrelated elements that support the operation of the proximal process. The second proposition highlights that proximal processes vary as a function of the characteristics of the developing person, the immediate environmental contexts, and the societal influences over time and throughout a person's lifespan (Bronfenbrenner, 1995; Bronfenbrenner & Morris, 2006). The two propositions coexist but are theoretically interdependent, as both involve a person's development from the perception of the proximal processes within which the person interacts and includes the elements of context and time (Bronfenbrenner, 1995; Bronfenbrenner & Morris, 2006). It is within proximal processes where the influence of person and context intersect to impact and foster development.

Counseling is a proximal process, which meets the criteria of both propositions. First, counseling is an interactive process between counselor and client which progresses and becomes more complex over time. Counseling may become progressively more complex as the counselor and client continue to meet, build rapport, and establish the

safety and trust to explore issues at a deeper level to promote a richer understanding of the client's issues. Second, counseling varies as a result of the counselor and client relationship and the characteristics of both counselor and client. As a proximal process, counseling incorporates reciprocal interactions during which counselors build rapport, evaluate client competence in the present, recognize the influence of history and societal expectations on client development, and provide opportunities for the client to engage in new ways of interaction to support development of new skills. It is also within the proximal process that the exposure to client trauma narratives has the potential to impact the counselor in training's experience of vicarious traumatization and posttraumatic growth

Person. The person interacts within multiple proximal processes across various system. Inherent in the person are three types of characteristics that combine to create a unique individual with distinctive elements that influence interactions. The person characteristics were termed force, resource, and demand (Bronfenbrenner & Morris, 2006). The characteristics are utilized to conceptualize individuals' characteristics that may influence the proximal processes in which those individuals engage. It is important to note that these characteristics can be applied to both counselor in training and client.

The person characteristics include demand, force, and resources, which interact together to influence the personal and professional development of the counselor in training. Demand characteristics include those aspects of the person that can easily be viewed and can alter or influence social interactions based on previous expectations or stereotypes (Bronfenbrenner & Morris, 2006). A counselor in training's demand

characteristics includes age, gender, skin color, and physical appearance (Tudge, Mokrova, Hatfield, & Karnik, 2009). The second characteristic, force, is a person's behavioral disposition or temperament that initiates, sustains, or prevents proximal processes from occurring (Bronfenbrenner & Morris, 2006). For the counselor in training, empathy, acceptance, and warmth are examples of force characteristics. Bronfenbrenner and Morris (2006) distinguished between force characteristics that are developmentally generative and developmentally disruptive. Characteristics or temperaments that support a counselor in training, for example curiosity and having a desire to learn ways to better help a client, would be categorized as developmentally generative. A disruptive force includes behaviors that are excessive and those that are underactive. The excessive disruptive behaviors include hyperactivity, distractibility, impulsivity, and emotional volatility (Bronfenbrenner & Morris, 2006). The underactive behaviors include apathy, inattention, and withdrawal (Bronfenbrenner & Morris, 2006). Each of these behaviors is likely to be encountered in clients during counseling sessions, though not at the same time. Developmentally disruptive behaviors may appear as oppositional defiant behaviors or attention deficit disorders. Depression would be categorized as an underactive behavior. Within the counselor in training, vicarious traumatization is considered a developmental disruptive force characteristic and posttraumatic growth a developmental generative force characteristic with each having the potential to influence the proximal process. The final personal characteristic to review, resources, includes one's abilities, experiences, knowledge, and skills (Bronfenbrenner & Morris, 2006). For counselors in training resource characteristics

include educational experiences, including practica and internship. Resource characteristics also include a person's current experiences, such in internship or supervision, and previous experiences, such as personal trauma history, and a person's social and material resources (Bronfenbrenner & Morris, 2006; Tudge et al., 2009). For counselors in training, resources also include any previous experiences, such as having a personal history of trauma. These resources may be drawn upon at any time in any context to assist in the interactions occurring in a proximal process (Bronfenbrenner & Morris, 2006).

The combinations of these characteristics or forms create distinct and unique patterns in the person, which impact the proximal process (Bronfenbrenner & Morris, 2006). For the counselor in training, the proximal process is also impacted by the person characteristics of the client. This assists in explaining how counselors in training, despite similar training, develop competency unique to their own professional identity as counselors. It is the interplay of these proximal processes and person characteristics in conjunction with context that places the person (i.e. the counselor in training and also the client) as both a producers and products of development within her or his environment (i.e. the counseling session). The interdependence of characteristics of the counselor in training and the client involved in the proximal process of counseling shapes the perception of experience, influences the strength of the process, and the developmental competence of the counselor in training and the client involved in the reciprocal interactions. However, the proximal processes cannot be fully evaluated without also examining the influence of context and time.

Context. Along with the proximal process and person characteristics is the environment or context in which the proximal processes occur. The environmental contexts include the nested systems originally described by Bronfenbrenner in earlier works (Bronfenbrenner 1977, 1978, 1979, 1988, 1994). These systems include the microsystem, mesosystem, exosystem, and macrosystem. The most near or immediate system an individual inhabits is the microsystem. Inside the microsystem are the face-to-face interactions that occur between the individual and other persons, symbols, or objects (Bronfenbrenner, 1977, 1994; Bronfenbrenner & Morris, 2006). When these interactions occur on a regular basis and with increasing complexity, the microsystem contains a proximal process. An example of the microsystem would be the internship site in which the counseling relationship between client and counselor in training takes place. The mesosystem is the connecting space or interactions between two or more systems that include the developing person, such as work and family, or school friends and home (Bronfenbrenner, 1977, 1994). While the microsystem and mesosystem involves the developing person directly, the exosystem includes at least one environment that does not include the developing person (Bronfenbrenner, 1994). The exosystem indirectly influences the interaction and a person's development within the microsystem (Bronfenbrenner, 1994). The final system, the macrosystem, involves the pattern of influential characteristics of culture or subculture with specific belief systems or customs, and influences the interactions within the other systems (Bronfenbrenner, 1994). Although counseling sessions occur in the microsystem, the counseling process is influenced by the other systems. These systems directly and indirectly impact a person's

development and the reciprocal interactions within proximal processes. According to Bronfenbrenner (1999),

...environmental contexts influence proximal processes and developmental outcomes not only in terms of the resources that they make available but also the degree to which they provide the stability and consistency over time that proximal processes require for their effective functioning (p. 23).

In order to understand the proximal process and the person, consideration of the various contexts in which the person interacts must be examined because the context influences a person's development and the persons, objects, or symbols with which the person interacts. Thus, it is important to understand and explore the different environments in which the counselor in training and client interact and how those various contextual interactions impact therapeutic relationship. An example of this contextual interaction involves the counselor in training engaging with clients in the proximal process inside a microsystem, while at the same time managing the information of his or her own personal trauma history or relational problems at home. In this example, the microsystem involves the counselor in training and client, while the exosystem involves the counselor in training's own personal historical information and resource characteristics. Each of these contexts potentially impacts the proximal process of counseling.

Time. The final element of the process, person, context model, is time.

Bronfenbrenner initially utilized the term chronosystem to represent the changes over time in the individual as well as changes in the environments in which the developing person lives (Bronfenbrenner, 1994). The elements of time described by Bronfenbrenner

and Morris (2006) include three successive levels with similar terminology as used in describing the environmental systems (Bronfenbrenner & Morris, 2006). The first level is described as microtime and includes the evaluation of the continuity or discontinuity of proximal processes (Bronfenbrenner & Morris, 2006). It is the evaluation of the starting and stopping of the interactions within a proximal process. For example, the continuity within a single counseling session can be evaluated at the microtime level. The counselor implements an intervention with a client and continues or discontinues the intervention based on the client's level of engagement and how the intervention supports the client's development. The counseling session may become discontinuous due to a client's preoccupation with email or receiving a phone call during the session. It is also possible for the session to become discontinuous because the counselor in training becomes less mindful or begins to tune out what the client is saying due to being overwhelmed with the traumatic narrative of the client. Mesotime is the second level of time. It involves the occurrence of proximal processes over broader time intervals of days or weeks (Bronfenbrenner & Morris, 2006). To continue with the previous example, mesotime would include the frequency of the counseling sessions and an evaluation of the continuity of the counseling as a whole. The effectiveness of the proximal process of counseling would be evaluated based on the frequency and continuity of counseling sessions in addition to the effectiveness of the techniques or interventions applied within the microtime level. The final level of time is macrotime. Macrotime encompasses the changes in societal expectations or events within and across generations (Bronfenbrenner & Morris, 2006). The macrotime level is similar to the zeitgeist or spirit of the times,

which according to Bronfenbrenner, would impact the proximal processes of the developing person. In addition, historical events at the macrotime level have the ability to impact a population or large segments of a population of which the counselor in training and client are just two individuals within the population (Bronfenbrenner, 1995). From the counseling perspective, macrotime would include the influences of societal views or historical events or experiences that have the potential to impact the individual, counselor in training, clients, and entire segments of a population. Examples of these events include the bursting of the dot-com bubble, the housing market crash, increasing unemployment, and natural disasters. Society's perception of mental health disorders, psychiatric medication, and the acceptance of counseling as an efficacious intervention would also influence the proximal processes of counseling.

Taken together, the elements of time in the bioecological model provide a way to evaluate the influence of proximal processes in the present situation where a person's development has been shaped by previous experiences, present reciprocal interactions, and is at the same time shaping a person's future development (Bronfenbrenner & Evans, 2000). Counseling is a proximal process that evaluates the client's competence in the present situation, recognizes the influence of history and societal expectations on development, and provides the opportunity for the client to engage in new ways of interacting that supports development.

Within Research. Researchers have utilized Bronfenbrenner's theory and pursued the evaluation of development within the nested systems and later added the element of time to describe developmental changes. However, researchers have failed to

utilize the mature form of the theory and have focused instead on contexts of development or on interactions between person and context, while ignoring the proximal processes in general. Hoffman and Kruczek (2011) described the impact of mass trauma on the individual, community, and society from an adapted perspective of Bronfenbrenner's bioecological model of human development. The researchers utilized "chronosystem" to characterize human developmental changes over time and implied similarity to proximal processes. Despite the description of proximal processes within the article, the researchers failed to adequately address the reciprocal interactions of the proximal process and the specific person characteristics that contribute to the reactions to mass trauma.

In defining the PPCT research model, Bronfenbrenner described a research process with simultaneous focus on proximal process, person, context, and time (Bronfenbrenner 1994, 2005). Bronfenbrenner defined the research design as a simultaneous evaluation because he recognized each element played a part in both influencing and being influenced by the elements of proximal process, person, context, and time. Therefore, the recognition of the influence of each element involved in the PPCT model provides a way to more fully evaluate human development.

Within the field of counseling research, attention to Bronfenbrenner's theory has predominantly been the application and evaluation of ecological systems. Of the thirteen research articles published between 2008 and 2014, found through EBSCO and PsychInfo research databases (Chun & Dickson, 2011; Feinstein, Barrtman, Buboltz, Sonnichsen, & Sollomon, 2008; Forrest, Miller, & Elam, 2008; Hong, Lee, Lee, Lee, &

Garbarino, 2014; Hooper & Britnell, 2010; Jacobs, Leach, & Gerstein, 2011; Jones, Meneses da Silva, & Soloski, 2011; Kissil, Davey, & Davey, 2013; McNeil & Murphy, 2010; Roysircar & Pignatiello, 2011; Shen-Miller, Isacco, Davies, Jean, & Phan, 2013; Woodson, Hives, Sanders-Phillips, 2010), only one (Liles & Juhnke, 2008) of the articles utilizes and discusses the mature version of Bronfenbrenner's inclusive of the PPCT research model in which the researchers evaluate adolescents with diabetes. The bioecological theory of human development along with the research design inherent in the PPCT model provides a way to evaluate a person's development. The PPCT model simultaneously examines the whole person, the reciprocal processes, and the interplay of contexts over a person's lifespan. Bronfenbrenner understood the importance of the scientific journey and its vigilance in continuing to change and evolve (Bronfenbrenner, 1999). The challenge to future research is to utilize the most mature form of Bronfenbrenner's bioecological theory of human development and implement the PPCT theoretical model in the research design so a more comprehensive evaluation of human development can be achieved. In this way, the journey and vigilance aspired to by Bronfenbrenner can move forward, evolve, and enhance the understanding of how a person develops and what influences their development. For the purposes of this study, the interplay of person characteristics of the counselor in training, time, context of the internship or practicum site, along with the intimate interactions within the proximal process of counseling will be explored so that a more complete picture of a counselor in training's initial engagement with clients can be highlighted and understood.

Empathy

Carl Rogers (1957) described empathy as one of the most important core conditions that is necessary and sufficient when working with clients. Empathy, as defined by Rogers, involves the counselors' ability to walk around in the client's private world and truly understand it as if it were their own. Additional definitions have described empathy as the art of understanding and the cognitive ability to understand the client's inner experiences and perspectives as well as the capability of the counselor to communicate this understanding (Brockhouse et al., 2011; Hojat, 2007). Empathy has further been described by Hojat (2007) as the perceptive ability to stand in another's shoes while also being tolerant, open, non-judgmental, and having unconditional acceptance. Harrison and Westwood (2009) utilized "exquisite empathy" to describe a way of being highly present, sensitively attuned, and well-boundaried while engaging with clients from an empathic perspective. The ability of counselors and counselors in training to empathically engage is a crucial component when working with clients (Sexton, 1999). For counselors in training, empathy is an important skill to utilize when beginning to engage with clients. Within the constructs of vicarious traumatization and posttraumatic growth, empathic engagement is the door that opens to the risk of being negatively impacted and the opportunity for growth.

Vicarious traumatization, as defined by Pearlman and Mac Ian (1995) and Pearlman and Saakvitne (1995a) described how empathic engagement with clients' trauma narratives leads to an inner transformation of counselor's beliefs about self, others and the world. The empathic engagement increases the risk for the counselor and

counselor in training to experience vicarious traumatization, which may result in physical, emotional, or cognitive symptoms similar to the clients they are treating (Pearlman & Saakvitne, 1995a, 1995b; Sexton, 1999). A military trauma therapist shared that as a result of working with trauma, “You become detached. You start to feel like you can’t connect with your patients. You run out of empathy.” (Carey, Cave, & Alvarez, 2009). Pearlman and Saakvitne (1995) warned that the “...loss of empathy with clients poses a profound danger to any therapy and can result in retraumatization ...” of clients (p. 289), which impacts the ethical obligation to do no harm. Sabin-Farrell and Turpin (2003) suggested that further studies are needed to better understand empathic engagement and its role in vicarious traumatization. A qualitative study by Harrison and Westwood (2009) described empathic engagement, the way in which counselors applied empathy in the therapeutic relationship, emerged as a protective factor against vicarious traumatization for experienced master and doctoral level clinicians who have worked with traumatized clients. Despite the appeal and the conceptualized importance of empathic engagement, researchers have failed to empirically evaluate how empathy influences vicarious traumatization, especially in counselors with less experience.

Unlike the studies on vicarious traumatization, empathic engagement has been included in two quantitative studies and one qualitative study about posttraumatic growth in counselors (Brockhouse et al., 2011; Goldenberg, 2002; Linley & Joseph, 2007). Brockhouse and colleagues examined the relationship of empathy, sense of coherence, and perceived organizational support from the perspectives of 118 trauma therapists. The researchers reported empathy as having a significant, negative and small moderating

effect between the relationship between vicarious exposure to trauma and posttraumatic growth (Brockhouse et al., 2011). In addition, Brockhouse and colleagues reported a positive correlation between empathy and posttraumatic growth. Linley and Joseph also found empathy to be an important variable when evaluating posttraumatic growth. The researchers reported empathy significantly predicted higher scores on the Posttraumatic Growth Inventory (Linley & Joseph, 2007). Another researcher, Goldenberg (2002), described themes of empathy and posttraumatic growth in her qualitative study with interviewers of Holocaust survivors. Participants in Goldenberg's study described having more compassion and stated they "...think [their] work has made [them] more sensitive to the feelings of others" (p. 222). Another participant noted having a greater appreciation for their own good fortune and stated, "I have a heightened sensitivity to the gift and the preciousness of my children" (Goldenberg, 2002, p. 222-223). The research demonstrates some support for the importance of empathic engagement related to posttraumatic growth but additional research is needed to more fully understand how empathy influences posttraumatic growth.

Empathic engagement is conceptualized as instrumental in developing a therapeutic relationship, but empirical support is limited regarding how empathic engagement influences the experience of vicarious traumatization and posttraumatic growth. Based on the recent literature review, this will be the first study to empirically link empathy with vicarious traumatization. In examining how empathy influences the levels of vicarious traumatization and posttraumatic growth among counselors in training,

additional information will be gleaned on how to best support and educate counselors in training on their journey to join the helping profession.

Counselors In Training

Counselors in training are defined as those master's level graduate students who are enrolled in a practicum or internship training course. The professional practice standard from CACREP (2009, 2016) requires counselors in training to complete an entry-level practicum of 100 hours and an entry-level internship totaling 600 hours. Both vicarious traumatization and posttraumatic growth are conceptualized to occur over time and researchers have supported the evaluation of these constructs among counselors with less than two years of experience (Pearlman & Mac Ian, 1995). However, a gap has remained about the counselors' beginning experiences of empathically engaging with clients in the research on vicarious traumatization and posttraumatic growth. This is unfortunate because counselors in training at the beginning of their professional training are poised to provide information about the initial accumulation of exposure to clients' trauma material and the beginning development of vicarious traumatization and posttraumatic growth.

According to Skovholt and Ronnestad (1992), counselors in the middle of their training and during internship are primarily tasked with imitating experts and functioning as a professional counselor. It is also a time of variable confidence and experiences of bewilderment, and temporary calm in relation to the development and refinement of skills (Skovholt & Ronnestad, 1992). During this time, counselors in training are tasked with translating information from textbooks into the practice of counseling while also trying to

manage boundaries and regulate their own emotions during counseling sessions (Skovholt & Ronnestad, 2003). This contributes to the counselors in training experiences of fear and anxiety. In addition, counselors in training may have exaggerated expectations of the proximal process of counseling, which elevates the risk for additional stressors and shifts in beliefs about their own competency (Skovholt & Ronnestad, 2003). From the perspective of CSDT and the research by Skovholt and Ronnestad (1992, 2003), counselors in training are at risk for experiencing disruption to their sense of self capacities, ego resources, and the psychological need and cognitive schemas of trust and esteem, which places them at risk for experiencing vicarious traumatization.

Based on their qualitative inquiry about vicarious traumatization with experienced mental health professionals, Harrison and Westwood (2009) suggested incorporating mindfulness training in counselor education. This would assist in helping counselors in training better balance ego resources and maintain self-capacities. In addition, Harrison and Westwood recommended that educational curriculum assist counselors in training to learn how to better tolerate ambiguity and embrace complexity, which would also assist in enhancing self capacities and ego resources. Another recommendation is related to sustaining empathy, an ego resource and person-force characteristic. Harrison and Westwood suggested counselors in training receive additional education around how to distinguish empathic engagement and sympathetic over-identification with clients. If counselors in training are not provided these resources, if working with clients becomes a burden, and if there is an insufficient ability to achieve work-life balance, then counselors

in training may choose to leave the helping profession. This would constitute a loss of resources and potential for the field of professional counseling (Harrison & Westwood, 2009).

Culver, McKinney, and Paradise (2011) asked mental health professionals how their coursework and fieldwork experiences assisted them in working with clients who had experienced trauma. The researchers reported that participants noted their fieldwork (internship) experiences better prepared them to work with trauma than the information obtained during educational courses (Culver, McKinney, & Paradise, 2011). Culver and colleagues (2011) reported a significant relationship between coursework preparation and altered perceptions of self. Fieldwork (internship) experiences were noted as having a negative relationship with negative psychological effects, which suggests that internship experiences can assist in counteracting the negative psychological effects of working with clients who have a trauma history (Culver et al., 2011). However, the researchers did not include the frequency or amount of supervision participants received, state if participants had a history of personal trauma, did not include the amount of exposure to client trauma, nor how much experience participants had in the field. This contributes to an unclear representation on how coursework and the experiences of practicum or internship might impact or protect against the development of vicarious traumatization and facilitate posttraumatic growth.

Based on the review of the literature it is clear that counselors in training would benefit more from trauma-related coursework (Culver et al., 2011) and learning more about the risks of working with clients who have a history of trauma (Brady, Guy,

Poelstra, & Brokaw, 1999). According to Brady, Guy, Poelstra, and Brokaw (1999), students should be made aware of how working with traumatized clients can cause distress and possible impairment as a way to normalize this experience and highlight that treatment may be necessary. In addition, counselors in training may benefit from learning more about posttraumatic growth. When counselors in training are aware of the potential to develop vicarious traumatization and posttraumatic growth, counselors in training will be forewarned, forearmed, and more prepared to enter and remain in the profession (Walker, 2004). In addition, Harrison and Westwood (2009) view the training about vicarious traumatization and posttraumatic growth as an ethical obligation. To support these claims and understand the initial experiences of empathically engaging with clients in the proximal process of counseling, the voices of counselors in training are necessary to add to the research on and understanding of vicarious traumatization and posttraumatic growth.

Personal Trauma History

Personal trauma history is a person resource characteristic often evaluated when looking at the level of a counselor's vicarious traumatization and posttraumatic growth. Counselors in training may have personally experienced a traumatic event, whether in childhood or adulthood, that has the potential to influence their perception of their self, others, and sense of safety. The personal trauma history also has the potential to impact the intimate interactional and developmental process of vicarious traumatization and posttraumatic growth that occurs inside the proximal process within the context of the therapeutic relationship. The following paragraphs will explore the multiple definitions

of trauma and the impact of personal trauma histories on the development of vicarious traumatization and posttraumatic growth.

Trauma is a term that has been utilized to describe many types of experiences that leaves a person feeling overwhelmed with the requirements of everyday living. Van der Kolk (1987) described trauma as an inescapable and stressful event that overwhelms a person's coping capabilities. Coping capabilities are also highlighted in the definition provided by The National Institute of Mental Health (NIMH, 2006), which delineates physical and mental trauma. According to NIMH (2006), physical trauma includes a person's bodily response to a serious injury or threat of injury. The mental trauma is the mind's response and includes frightening thoughts and emotions that occur in response to serious injury (NIMH). In addition, NIMH states that extreme behaviors can occur in response to trauma that include intense fear, helplessness, withdrawal, lack of concentration, irritability, sleep disturbance, and flashbacks. These symptoms are similar to the symptoms of vicarious traumatization. Another agency, the Substance Abuse and Mental Health Services Administration (SAMHSA; 2012) defines trauma as an event or series of circumstances experienced by an individual as physically or emotionally harmful or threatening that cause adverse effects on an individual's functional physical, social, emotional, or spiritual well-being. Trauma can also be experienced by groups of individuals such as a natural disaster or war. According to the United Nations Department of Economics and Social Affairs (July, 2010) a natural disaster is defined by an event in nature, which causes injury, displacement from one's home, and requires emergency assistance. Saylor (1993) also included that the natural disaster must be

“...traumatic enough to induce distress in almost anyone, regardless of premorbid function or earlier experiences” (p. 2). The above definitions make it clear that first an event must happen and second the person must experience or describe the event as traumatic. Within the research literature on vicarious traumatization and posttraumatic growth, the inquiry about personal trauma history has ranged from a simple yes or no response to having a personal trauma history, to providing a list of traumatic events to select. The common theme still remains that the person or counselor in training must consider the event to have been traumatic. For the purpose of this study, the definition of trauma will be provided on the surveys to ensure a common understanding by all participants. Trauma will be defined as an event, series of events, or set of circumstances experienced by an individual or a group that can cause physical and/or psychological stress reactions that is experienced by an individual as physically or emotionally harmful, threatening, or overwhelming and has lasting adverse effects on the individuals physical, social, emotional, or spiritual well-being (SAMHSA, 2012).

Regardless of the type of event, counselors in training who report having a personal history of trauma have an increased potential to develop vicarious traumatization. Researchers have evaluated the influence of personal trauma history on the development of vicarious traumatization (Baird & Kracen, 2006; Brandon, 2000; Jordan, 2010; Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Trippany, 2000; Trippany, Wilcoxon, & Satcher, 2003). Pearlman and Mac Ian (1995), in their study of 136 trauma therapists, reported counselors with a personal trauma history exhibited higher levels of vicarious traumatization that was significantly different than those

counselors without a trauma history. In a review of the literature, Baird and Kracen (2006) synthesized vicarious traumatization research articles and dissertations and cited three additional articles where researchers also described personal trauma history as influencing or related to vicarious traumatization. Trippany, Wilcoxon, and Satcher (2003) reported personal trauma history as a significant predictor of vicarious traumatization for therapists working with clients who had a history of sexual trauma based on the multiple regression analysis. Young (1999) reported that personal trauma history correlated significantly with vicarious traumatization among psychologists working with children with an abuse history. In contrast, Schauben and Frazier (1995), Brandon (1999), and Adams, Matto, and Harrington (2001) reported no significant relationship between personal trauma histories on the development of vicarious traumatization. However, Schauben and Frazier (1995) and Adams and colleagues (2001) only utilized five to six of the ten subscales of the Traumatic Stress Institute Belief Scale (TSI, Pearlman & Mac Ian, 1993; Pearlman, 1996) when assessing for vicarious traumatization, which may have contributed to why personal trauma history was not found to be significant. Based on the review of research, more results indicate that counselor's with a personal trauma history are at a greater risk for developing vicarious traumatization. Although some researchers describe personal trauma history as not being a risk there is concern that the way personal trauma history was assessed may have contributed to the differences in results. For example, asking professionals if they have a personal trauma history as in the studies by Pearlman and Mac Ian (1995) and Trippany and colleagues (2003) produced different and more significant results than

when researchers asked professionals to select what traumas they have experienced based on a provided list such as in the studies by Brandon (1999) and Schauben and Frazier (1995). In addition, these studies have included multiple disciplines and educational levels in the same study (Brandon, 1999; Camerlengo, 2002; Pearlman & Mac Ian, 1995), included a range of years in experience (Adams et al., 2001; Brandon, 1999; Camerlengo, 2002; Pearlman & Mac Ian, 1995; Trippany et al., 2004), and measured supervision dichotomously (Pearlman & Mac Ian, 1995; Young, 1999) or not included supervision (Adams et al., 2001; Brandon, 1999; Schauben & Frazier, 1995), which may have impacted and diffused these results. These results indicate that further research and clarification are needed as to how personal trauma history impacts vicarious traumatization.

There is also conflicting evidence when evaluating the influence of personal trauma history on posttraumatic growth. In a quantitative study, Brockhouse and colleagues (2011) reported no differences between counselors with and without a history of personal trauma in their evaluation of exposure to trauma and posttraumatic growth. However, this has not been the same across other studies. In evaluating counselors who provided volunteer counseling services after Hurricane Katrina and Hurricane Rita, Lambert and Lawson (2013) reported higher levels of posttraumatic growth among counselors who had been personally impacted by the hurricanes than those volunteers who had not been personally impacted. In addition, Linley and Joseph (2007) in their exploration of positive and negative well-being of therapists reported greater levels of posttraumatic growth among therapists with a personal trauma history than therapists

without a trauma history. In a qualitative study conducted by Arnold, Calhoun, Tedeschi, and Cann (2005), 17 of the 21 participating clinicians had experienced a traumatic event. The traumatic events included death of a sibling, death of a spouse, serious physical illness or disability, miscarriage, domestic violence, and war (Arnold, Calhoun, Tedeschi, & Cann, 2005). The researchers reported 90% of the participants responded that watching the client's growth impacted their positive outlook and 76% of participants reported a positive impact on their spirituality (Arnold et al., 2005). Inconsistencies in the results of the above studies may be linked to the varied amount of age and experience (Brockhouse et al., 2011; Lambert & Lawson, 2013; Linley & Joseph, 2007), inclusion of supervision (Linley & Joseph, 2007), and exclusion of supervision (Lambert & Lawson, 2013). Based on this review of the research literature, additional research is needed to further explore how personal trauma history impacts the development of posttraumatic growth.

It is unclear how a counselor's personal experience of trauma impacts the intimate interactions within the proximal process and the manifestation of vicarious traumatization and posttraumatic growth. The experience of a traumatic event influences the counselor in training first as a person resource characteristic and second as a person force characteristic. The experience of a traumatic event influences the person resource characteristic, as it is the experience a counselor in training has in their own personal history. As a person force characteristic the traumatic experience shapes the behavioral disposition and temperament of the counselor in training, such as the level of empathy, vicarious traumatization, and posttraumatic growth. It is hoped that by evaluating both

constructs within one study a clearer understanding of how personal trauma history influences a counselor in training's experience within the proximal process of counseling and the level of vicarious traumatization and posttraumatic growth will be gained.

Exposure to Clients with a Trauma History

The amount of exposure to client trauma narratives can be viewed as a person resource characteristic. Exposure to client trauma has been measured by examining the number of years counselors have worked with clients who have experienced trauma (e.g. Baird & Jenkins, 2003; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995), by calculating the percentage of clients with a trauma history on a counselor's caseload (e.g. Cunningham, 2003; Pearlman & Mac Ian, 1995), and the percentage of weekly counseling hours devoted to working with clients who have a trauma history (e.g. Bober & Regehr, 2006; Linley & Joseph, 2007). According to constructivist self-development theory (CSDT), cumulative exposure and the amount of time thinking about client trauma narratives places the counselor at risk for developing vicarious traumatization. Researchers studying posttraumatic growth report that counselors with greater years of experience have higher levels of posttraumatic growth (e.g. Brockhouse et al., 2011; Linley & Joseph, 2007). For counselors in training, it is unclear how initial empathic engagement with clients and exposure to clients with a trauma history impact the development of vicarious traumatization and posttraumatic growth.

According to Saakvitne and Pearlman (1996), work setting and caseload have a profound effect on the counselor's vulnerability to vicarious traumatization. The researchers suggested that having high caseloads focused on treating clients with trauma

histories, places counselors at a higher risk for developing vicarious traumatization due to the increased exposure to clients with trauma. Pearlman and Mac Ian (1995) reported exposure to client trauma significantly correlated with the length of time working with clients who have a trauma, work setting, and education level. In their study, Pearlman and Mac Ian (1995) described counselors with a personal trauma history and years of working with traumatized clients as negatively correlated with vicarious traumatization. Schauben and Frazier (1995) also reported that counselors with a higher percentage of sexual violence survivors on their caseload significantly predicted vicarious traumatization. In addition, Baird and Jenkins (2003) evaluated caseload in relation to vicarious traumatization among volunteer and paid domestic violence agency staff. The researchers reported a negative relationship between caseload and scores on vicarious traumatization as measured by the TSI-BSL (Pearlman, 1996). The results reported by Baird and Jenkins (2003) suggests that workers, who saw more clients with trauma histories, regardless of education level, had fewer symptoms of vicarious traumatization. It is important to note that Baird and Jenkins did not collect any client characteristics, information about personal trauma history, and included participants whose education level varied from high school to doctorate. Cunningham (2003) evaluated the years of experience in relation to vicarious traumatization with clinicians who specialized in treating sexual abuse or clients with cancer and also reported a negative relationship. Based on the studies previously described there is indication that fewer years of experience and greater number of clients with a trauma history on one's caseload poses a greater risk for the development of vicarious traumatization.

There is limited information about how the amount of exposure to trauma impacts the development of posttraumatic growth. Brockhouse and colleagues (2011) examined the amount of exposure to vicarious trauma in relation to posttraumatic growth among 118 British therapists. The researchers calculated exposure to trauma by collected information about the counselors' years of experience, hours spent per week with clients, and percentage of exposure to vicarious trauma, and number of clients with posttraumatic stress disorder for one month. This information was then calculated to reflect a total vicarious exposure to trauma score. The researchers reported that a higher amount of vicarious trauma exposure significantly predicted posttraumatic growth. Brockhouse and colleagues (2011) noted that posttraumatic growth was significantly related to age and empathy. Linley and Joseph (2007) also evaluated posttraumatic growth in relation to the number of hours counselors worked with clients who have experienced trauma. The researchers reported a significant relationship between hours spend working with traumatized clients and posttraumatic growth. These studies reflect a need for continued research to confirm how the amount of exposure to trauma impacts a counselor in training's development of posttraumatic growth.

In order to more clearly understand how the amount of exposure to trauma influences counselors, both vicarious traumatization and posttraumatic growth will be evaluated in counselors in training. According to the reviewed research less experience as a counselor increases the risk of vicarious traumatization, which suggests that counselors in training are also at risk. In addition, the research indicates that more experience and being older contributes to the development of posttraumatic growth which

makes it unclear how counselors in training might express posttraumatic growth. This study will evaluate exposure by comparing the number of clients counselors in training provide services to who have a history of trauma and the total number of clients on the trainee's caseload. It is hoped that looking at these constructs in relation to exposure will provide information on how the initial experiences within the proximal process of counseling impacts vicarious traumatization and posttraumatic growth.

Supervision

The prevalence of traumatic experiences increases the chances for counselors to encounter trauma narratives and therefore makes it crucial that counselors be adequately prepared and receive supervision that is collaborative and encourages counselors to be reflective (Sommer & Cox, 2006). The American Counseling Association (2005, 2014) mandates that counselors be aware of any sign of personal impairment and avoid providing services if impaired. Vicarious traumatization is a form of impairment. Supervision is described as the ethical component in minimizing impairment to counselors and minimizing the risk of harm to clients (Harrison & Westwood, 2009). In addition, supervision and consultation have been described as beneficial to counselors who encounter client trauma narratives (Calhoun & Tedeschi, 1999). Supervision is also described as an essential component of healing vicarious traumatization and facilitating posttraumatic growth (Bell, Kulkarni, & Dalton, 2003).

Supervision has been described and conceptualized as a protective factor to help prevent the development of vicarious traumatization (e.g., Jordan, 2010; Knight, 2004; Rosenbloom, Pratt, & Pearlman, 1995; Sommer, 2008; Trippany et al., 2004). Pearlman

and Saakvitne (1995) conceptualized supervision as a forum for developing strategies to address, manage, and decrease the effects of vicarious traumatization. Rosenbloom, Pratt, and Pearlman (1999) also recommended that counselors working with clients who have experienced trauma receive ongoing supervision, regardless of licensure requirements. Despite the noted importance of supervision, Brady and colleagues (1999) reported only 37% of experienced clinician participants working with clients that had a sexual abuse history received supervision. However, Brady and colleagues (1999) did not report how the lack of supervision impacted the clinician's level of vicarious traumatization. Harrison and Westwood (2009) also described supervision as a protective factor against developing vicarious traumatization. In their qualitative study utilizing narrative methodology, the researchers described supervision as a way to counteract isolation and decrease feelings of shame for experiencing symptoms of vicarious traumatization. The researchers reported that supervision, whether formal, informal, peer, group, or paid consultation, was described as helpful. Despite the number of studies in which researchers have conceptualized supervision as an important component against the development of vicarious traumatization, few studies have empirically tested supervision as an influential factor.

Supervision has also been found to support the development of posttraumatic growth. In a qualitative study by Harrison and Westwood (2009), participants were reported to describe being "...invigorated rather than depleted by their intimate professional connections with traumatized clients" (p. 213). This is indicative of posttraumatic growth. Linley and Joseph (2007) reported greater levels of posttraumatic

growth among counselors who received supervision than those who reported no supervision. In addition, Brockhouse and colleagues (2011) evaluated supervision as occurring or not occurring in registered therapists. The researchers described therapists who received supervision as exhibiting higher scores of posttraumatic growth but reported that supervision was not significantly correlated to posttraumatic growth (Brockhouse et al., 2011). Linley and Joseph (2007) and Brockhouse and colleagues (2011) did not report the frequency or amount of supervision received, which may have influenced results. As with the other variables explored as facilitative of posttraumatic growth in counselors and counselors in training, additional research is needed to clearly identify supervision as a supportive factor.

Supervision is an ethical requirement for counselors in training and counselors seeking independent license. According to Etherington (2000) supervision can be a safe harbor in which counselors can express and explore their feelings about their clients and their work. However, it remains empirically unclear how supervision impacts the experience of vicarious traumatization and posttraumatic growth. In reviewing the literature there are indications that receiving supervision is important to managing the symptoms of vicarious traumatization and facilitating posttraumatic growth. However, additional empirical research is needed to support these claims. In this study, the total number of supervision hours will be evaluated in relation to the observed levels of vicarious traumatization and posttraumatic growth among counselors in training.

Summary

The experience of vicarious traumatization and posttraumatic growth has been conceptualized from the frameworks of CSDT. For the purposes of this study, CSDT and Bronfenbrenner's PPCT research model will be utilized as a theoretical framework. What remains unclear is the how counselors in training might experience vicarious traumatization and posttraumatic growth as a result of their initial experiences of empathically engaging with clients within the proximal process of counseling. In addition, the variables of empathy, personal trauma history, exposure to clients with a trauma history, and supervision have not been explored within the context of the proximal process of counseling for counselors in training. In order to deepen the understanding of the intimate and reciprocal interactions between the counselor in training and client and further the understanding of how these variables impact vicarious traumatization and posttraumatic growth a mixed methods evaluation of these constructs is proposed. The emphasis on empathy, personal trauma history, exposure to client trauma, and supervision will highlight areas where additional support and training for counselors in training is needed. This process will involve a combination of exploring empathic engagement, the evaluation of psychological and cognitive schema entailed in vicarious traumatization and posttraumatic growth, and an appreciation for the paradox of experiencing both negative the aspects of working with trauma along with the potential for growth (Tedeschi & Calhoun, 2004). In this way, the voices of counselors in training will assist in illuminating the initial process of empathic engagement with clients and

how the counselor in training's own personal experience of trauma, exposure to client trauma narratives, and supervision influence vicarious traumatization and posttraumatic growth.

CHAPTER III

METHODOLOGY

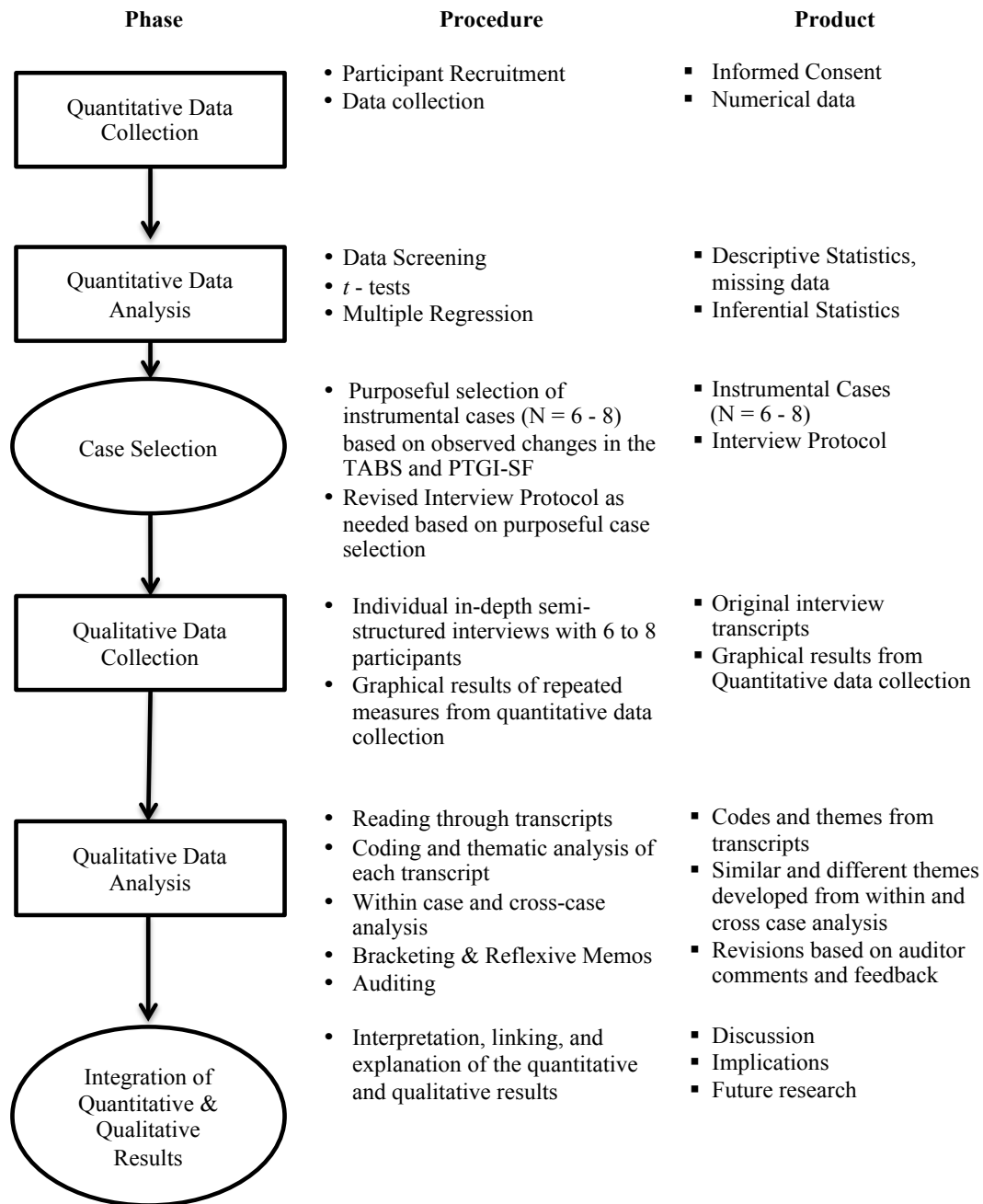
Introduction

In this chapter, the researcher will provide a detailed description of the research questions, hypotheses, participant selection, instrumentation, procedures, and data analyses for this study. In addition, the researcher has included in this chapter an overview of the study design along with the theoretical and methodological frameworks that have guided and supported the development of this study.

Explanatory Sequential Mixed Method Design

The researcher will implement an explanatory sequential mixed methods design. The explanatory sequential mixed methods design entails the collection of quantitative data followed by the collection of qualitative data. The collection of qualitative data provides the opportunity for participant voices to give depth and meaning to the interpretation and understanding of the quantitative results. Accordingly, the study will be conducted in two phases with the quantitative occurring first and the qualitative phase occurring second. (See Figure 1 for visual model of explanatory sequential mixed methods design procedures.)

Figure 1. Visual Model for the Explanatory Sequential Mixed Methods Design



Note. TABS refers to the Trauma and Attachment Beliefs Scale (TABS; Pearlman, 2003). PTGI-SF the Posttraumatic Growth Inventory-Short Form (PTGI-SF; Cann et al., 2010).

All data in this study was obtained from participants who are counselors in training at institutions that have received accreditation by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). During Phase 1, the quantitative portion, participants were asked to complete a survey that contained demographic questions and standardized measures of empathy, vicarious traumatization, and posttraumatic growth. In Phase 2, the researcher employed semi-structured interviews with counselors in training who were purposefully selected based on their scores on the vicarious traumatization and posttraumatic growth instruments. The qualitative phase utilized a multiple case study designed to explore the initial proximal process of counseling clients and help explain the levels of vicarious traumatization and posttraumatic growth obtained on the standardized instruments. Bronfenbrenner's (2005) process, person, context, and time (PPCT) research model have been utilized as theoretical and conceptual frameworks for data collection and variable selection.

Proximal Process-Person-Context-Time Research Model

The PPCT research model designed by Bronfenbrenner (2005) will also be utilized as a guide for this study. In order to implement Bronfenbrenner's (2005) PPCT research model it is necessary to review the elements of proximal process, person characteristics, context, and time that will be evaluated during this study. Bronfenbrenner (2005) described proximal process as reciprocal interactions that happen within and across systems or environments, and time. For counselors in training, the proximal process involves the initial and ongoing reciprocal interactions with clients that occur in and across counseling sessions. The proximal process will be evaluated in the

semi-structured interviews with those counselors in training who were purposefully selected to participate in Phase 2.

The second “P” in the PPCT model represents the person characteristics of the counselor in training through evaluation of demand, force, and resources. The person demand characteristics include age, gender, skin color, and physical appearance (Tudge, Mokrova, Hatfield, & Karnik, 2009). For the purposes of this study, person demand characteristics of age, gender, race, and ethnicity were collected from study participants on the demographic section of the survey. The person force characteristic includes a person’s behavioral disposition or temperament that initiates, sustains, or prevents proximal processes from occurring (Bronfenbrenner & Morris, 2006). This study included measures of empathy, vicarious traumatization, and posttraumatic growth, which have the ability to impact the proximal process in which the counselor in training is involved. The final person characteristic, person resources, includes one’s abilities, experiences, knowledge, and skills (Bronfenbrenner & Morris, 2006). Person resource characteristics in this study were evaluated through questions about a participant’s access to supervision, personal trauma history, and educational information.

The final elements in the PPCT research model are context and time. The “C” in the PPCT research model denotes the context or environment where the proximal processes occur (Bronfenbrenner 1977, 1978, 1979, 1988, 1994). For the counselors in training participating in this study, information about the setting of the practicum or internship site was obtained from answers on the survey and from the semi-structured interviews. The “T” from the PPCT research model represents time. The

implementation of time from Bronfenbrenner's (2005) PPCT research model entails the acknowledgment of time that influences the consistency or change across a person's development (Eamon, 2011). For this study, the analysis of time will be evaluated by examining the elements of time mentioned by counselors in training during the semi-structured interviews.

Research Questions and Hypotheses for Phase 1: Quantitative

The following research questions and hypotheses were examined in the quantitative portion of the study in Phase 1.

Research Question 1: What are the levels of vicarious traumatization and posttraumatic growth among counselors in training?

Hypothesis 1a: It is expected that counselors in training will exhibit vicarious traumatization and posttraumatic growth, but it is unknown what level of these constructs will be exhibited as this is the first study to only examine counselors in training.

Research Question 2: Are the levels of vicarious traumatization and posttraumatic growth among counselors in training significantly differentiated by personal trauma history, amount of exposure to client trauma, and number of supervision hours?

Hypothesis 2a: Counselors in training who have a history of personal trauma will score higher on measures of vicarious traumatization and posttraumatic growth than counselors who do not have a personal history of trauma.

Hypothesis 2b: Counselors in training who are exposed to more clients with a trauma history will score higher on measures of vicarious traumatization and

posttraumatic growth than counselors in training who have little to no exposure to clients with a trauma history.

Hypothesis 2c: Counselors in training who receive more hours of supervision will demonstrate lower scores on measures of vicarious traumatization and higher scores on measures of posttraumatic growth than counselors in training who receive less hours of supervision.

Research Question 3: How does empathy along with person characteristics found to be significant in Research Question 2 (i.e. personal trauma history, exposure to clients with trauma, hours of supervision) influence levels of vicarious traumatization and posttraumatic growth among counselors in training?

Hypothesis 3a: Among counselors in training, the level of vicarious traumatization and posttraumatic growth will be dependent upon empathy, personal trauma history, amount of exposure to clients with a history of trauma, and hours of supervision.

Research Questions for Phase 2: Qualitative

The following questions are qualitative in nature; therefore no hypotheses were made regarding how the counselors in training might respond. Instead the voices of counselors in training provided responses to questions during a semi-structured interview allowing similar and dissimilar themes to emerge.

Research Question 4: How do counselors explain the change or lack of change that occurred in the repeated administrations of the measures for vicarious traumatization and posttraumatic growth?

Research Question 5: How do counselors in training describe their experiences within the proximal process of providing counseling services to clients who have experienced trauma?

Phase 1: Quantitative Portion

Sample and Participant Selection

The researcher obtained permission from the Institutional Review Board (IRB) at the University of North Carolina at Greensboro to conduct the study. Participants recruited for Phase 1 of the study were master's level counselors in training who were completing their internship at graduate institutions that had received CACREP accreditation. The professional practice standard from CACREP (2009; 2016) requires counselors in training to complete an entry-level practicum of 100 hours followed by an entry-level internship of 600 hours. Participants who were not enrolled in a counseling internship were not eligible to participate in this study.

To recruit perspective participants, the researcher emailed faculty at 17 graduate institutions that asked faculty to forward an email to students who met the above stated criteria, inviting them to participate in the study. The invitation email forwarded to students provided information about the study and asked interested students to click on a link that forwarded them to a secure Qualtrics online survey that contained the informed consent, survey, and optional contact information.

All participants who completed the survey were provided a list of resources for addressing vicarious traumatization and sustaining wellness throughout their professional counseling career. These resources were located at the end of the survey and could be

printed by the participant. Participants who completed the survey in its entirety and provided a contact email address received a personal thank you and a \$5 e-gift card to their choice of Amazon.com, Target, Panera, or Starbucks within one month of completing the survey. Participants who completed the survey and volunteered to be a potential participant in the semi-structured interview process also received their results on the measures of vicarious traumatization and posttraumatic growth at the end of the study. The results included a graph and written explanation of the scores. Participants who were selected and completed the semi-structured interview received their results score report and a \$10 e-gift card to their choice of Amazon.com, Target, Panera, or Starbucks. The participants who completed the semi-structured interview received their incentive within 24 hours after the interview.

According to G*Power (Version 3.1.7), to obtain a moderate effect size and power of .80 to compute the data analyses in Phase 1 of the study and offset attrition, an estimated sample size of at least 82 and at most 200 participants was sought. (See Table 1 for data analysis plan for the quantitative portion, Phase 1 of the study.)

Table 1

Data Analysis Plan for Phase 1: Quantitative Portion

Research Question	Hypotheses	Data Analysis
RQ1: What are the levels of vicarious traumatization and posttraumatic growth among counselors in training?	H1a: It is expected that counselors in training will exhibit vicarious traumatization and posttraumatic growth, but it is unknown what level of these constructs will be exhibited as this is the first study to only examine counselors in training.	Descriptive Statistics: Mean, Minimum, Maximum; Standard Deviation
RQ2: Are the levels of vicarious traumatization and posttraumatic growth significantly differentiated by personal trauma history, amount of exposure to client trauma, and number of supervision hours?	H2a: Counselors in training who have a history of personal trauma will score higher on measures of vicarious traumatization and posttraumatic growth than counselors who do not have a personal history of trauma.	Descriptive Statistics: Mean, Minimum, Maximum; Standard Deviation IV: Personal trauma history, Exposure to client's with a trauma history, and Hours of supervision

Table 1 (Continued)

Data Analysis Plan for Phase 1: Quantitative Portion

Research Question	Hypotheses	Data Analysis
G*Power Analysis of estimated sample size to reach moderate effect size with power of .80 = 34	H2b: Counselors in training who are exposed to more to clients with a trauma history will score higher on measures of vicarious traumatization and posttraumatic growth than counselors in training who have little to no exposure to clients with a trauma history.	DV: VT and PTG
RQ2: Are the levels of vicarious traumatization and posttraumatic growth significantly differentiated by personal trauma history, amount of exposure to client trauma, and number of supervision hours?	H2c: Counselors in training who receive more hours of supervision will demonstrate lower scores on measures of vicarious traumatization and higher scores on measures of posttraumatic growth than counselors in training who receive less hours.	Descriptive Statistics: Mean, Minimum, Maximum; Standard Deviation IV: Personal trauma history, Exposure to client's with a trauma history, and Hours of supervision
G*Power Analysis of estimated sample size to reach moderate effect size with power of .80 = 34		DV: VT and PTG

Table 1 (Continued)

Data Analysis Plan for Phase 1: Quantitative Portion

Research Question	Hypotheses	Data Analysis
RQ3: How do empathy and person characteristics found to be significant in RQ2 (i.e. empathy, personal trauma history, exposure to clients, and hours of supervision) influence vicarious traumatization and posttraumatic growth among counselors in training across time?	H3a: Among counselors in training, the level of vicarious traumatization will be dependent upon empathy, personal trauma history, amount of exposure to clients with a history of trauma, and amount of supervision.	Hierarchical Regression Commonality Analysis IV: Empathy, Personal trauma history; Exposure to clients with trauma; Hours of supervision DV: VT and PTG
G*Power Analysis of estimated sample size to reach moderate effect size with power of .80 = 55 (up to 77 based on number of significant variable in RQ2)	H3b: Among counselors in training, the level of posttraumatic growth will be dependent upon empathy, personal trauma history, amount of exposure to clients with a history of trauma, and amount of supervision.	

Note. IV = Independent Variable. DV = Dependent Variable. VT = Vicarious Traumatization. PTG = Posttraumatic Growth.

Instrumentation

Demographic Questionnaire. Counselors in training who agreed to participate were asked 17 questions on the demographics section of the survey. Open-ended questions asked participants to list their age and requested the total number of credit hours completed in their graduate counseling program at the time of the study. For the following questions, counselors in training selected a choice from a pre-determined list to

answer the state in which they resided during graduate school, gender, counseling track, if attending a masters or doctoral program, if attending graduate school part-time or full-time, race and ethnicity, relationship status, if currently enrolled in practicum or internship, primary setting of current practicum or internship, primary age of clients or students whom they are currently working with at the practicum or internship site, approximate number of clients seen during current semester who have a history of trauma, what types of trauma were reported by clients, who provides supervision, the frequency and type of supervision received, and the average hours of supervision received weekly. If an answer was not found on the pre-determined list, an option of “other” was provided with room for the counselor in training to provide the other information. In addition, counselors in training were asked if they have a history of personal trauma (yes or no) and if yes, to select what type(s) of trauma they had experienced. (See Appendix A for Informed Consent. See Appendix B for the Demographic Questionnaire and Copies of Standardized Measures.)

Vicarious Traumatization. (Appendix B) The Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) was used to measure vicarious traumatization. The TABS (Pearlman, 2003) measures cognitive disruptions occurring as a result of vicarious traumatization as conceptualized by the CSDT. According to CSDT, the more trauma a counselor is exposed to the more disruption to the person’s basic beliefs and assumptions about their self, others, and the world. The disruption can lead to changes in how a counselor views their personal need for safety, trust, esteem, intimacy, and control. The

TABS (Pearlman, 2003) is the updated version of the former Traumatic Stress Institute Belief Scale-Revision L (Pearlman, 1996), revised to improve readability.

The TABS contains 84 questions written at a 3rd grade reading level.

Respondents answer on a 6-point Likert-type agreement scale (1 = strongly disagree to 6 = strongly agree) and can be completed in 15 to 20 minutes. The total score on the TABS indicates the amount of cognitive disruption to beliefs about the self, others, and world. The total score obtained on the TABS (Pearlman, 2003) ranges from the lowest score of 84 to highest score of 504. The raw scores can be transformed into standardized T scores for comparison. The T score has a mean of 50 and a standard deviation of 10. Scores range from very little disruption to substantial disruption with higher scores indicating more disruption.

The TABS yields scores for each of the 10 subscales and a total overall score. For the purposes of this study, only the total overall score were utilized. The subscales provide information related to a counselor's disruption of beliefs related to the psychological needs of safety, trust, esteem, intimacy, and control. The subscale items are separated into perceptions of self and other. Example items include the following: "I feel threatened by others" (self-safety); "I never think anyone is safe from danger" (other safety); "I often doubt myself" (self-trust); "Trusting people is not smart" (other-trust); "I'm not worth much" (self-esteem); "People are no good" (other-esteem); "I hate to be alone" (self-intimacy); "I feel cut off from people" (other-intimacy); "I have problems with self-control" (self-control); and "I can't do good work unless I am the leader" (other-control). Internal consistencies for the subscales are as follows: self-safety (.83),

other-safety (.72), self-trust (.74), other-trust (.84), self-esteem (.83), other-esteem (.82), self-intimacy (.67), other-intimacy (.87), self-control (.73), and other-control (.75). The reported Cronbach's alpha for overall TABS is .96 (Pearlman, 2003). Williams, Helm, and Clemens (2012) utilized the full scale of the TABS to evaluate vicarious traumatization in clinical mental health counselors working in community mental health centers. The authors reported an overall total score Cronbach alpha reliability estimate of .95 (Williams et al., 2012). The internal scale reliability for the current study achieved a Cronbach alpha of .950.

Pearlman (2003) reported interscale correlations, factor structure, and correlations with similar instruments to support construct validity. Pearlman (2003) reported subscales were highly intercorrelated with one another and that each subscale was more highly correlated to the total TABS score than to any other subscale. Varra, Pearlman, Brock, and Hodgson (2008) investigated the factor structure of the TABS (Pearlman, 2003). The researchers described a three-factor solution inclusive of self, other, and safety (world), which is consistent with CSDT and the subscales of the TABS (Varra, Pearlman, Brock, & Hodgson, 2008). Pearlman (2003) examined the correlations of TABS scores with scores on the Trauma Symptom Inventory (TSI: Briere, 1995) and reported the total scores of the TABS to be highly correlated with the TSI subscales of depression, dissociation behavior, and impaired self-reference, which reflect an internal process of experiences.

Criterion related validity of the TABS was supported by multiple researchers who have assessed vicarious traumatization among persons who have experienced trauma

directly (Dutton, Burghardt, Perrin, Chrestman, & Halle, 1994; Goodman & Dutton, 1996; Mas, 1992) and indirectly (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). These researchers reported that persons who have a history of trauma and therapists with greater exposure to client trauma exhibited higher scores on the TABS than those persons without a trauma history or less exposure to client trauma.

Posttraumatic Growth. (Appendix B) The Posttraumatic Growth Inventory-Short Form (PTGI-SF; Cann, et al., 2010) assesses the extent to which individuals believe they have positively changed after exposure to a traumatic event. The PTGI-SF is an abbreviated form of the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) and can be completed within five minutes. Cann and colleagues (2010) based the PTGI-SF on the longer PTGI and described the shorter form as psychometrically sound for use as a brief assessment tool of posttraumatic growth. Although the PTGI was originally designed to measure growth after direct experience to trauma, the measure has been utilized to measure indirect exposure to trauma in counselors (e.g. Brockhouse et al., 2011; Linley & Joseph, 2007). Brockhouse and colleagues (2011) reported a Cronbach alpha of .95 for internal consistency when using the PTGI. It is important to note that Tedeschi and Calhoun (1996) reported the PTGI did not correlate with social desirability. The current study was the first to utilize PTGI-SF to assess posttraumatic growth in counselors.

The PTGI-SF (Cann et al., 2010) consists of 10 questions, which asks respondents to answer on 6-point Likert Scale (0 = I did not experience this change; I experienced this change to a 1 = very small degree, 2 = small degree, 3 = moderate degree, 4 = degree, 5 =

very great degree). The PTGI-SF evaluates growth along five dimensions (i.e., relating to others, new possibilities, personal strength, spiritual change, and appreciation of life). Example items include the following: “I have a greater sense of closeness with others” (relating to others); “I established a new path for my life” (new possibilities); “I discovered that I am stronger than I thought I was” (personal strength); “I have a better understanding of spiritual matters” (spiritual change); and “I have a greater appreciation for the value of my own life” (appreciation of life). Despite the PTGI-SF having five underlying factors, a total score is used to represent the amount of posttraumatic growth with higher scores indicating more growth (Cann et al., 2010). The total scores can range from 0 to 50. For the purposes of this study, only the total scores were utilized.

Researchers have conducted studies to explore and validate the internal reliability of the PTGI-SF (Cann et al., 2010). Calhoun, Tedeschi, Fulmer, and Harlan (2000) examined posttraumatic growth in 32 parents who had lost a child. The researchers reported a coefficient alpha internal reliability estimate of .84 (Calhoun, Tedeschi, Fulmer, & Harlan, 2000). Another study by Cobb, Tedeschi, Calhoun, and Cann (2006) reported a coefficient alpha internal reliability estimate of .90 when they examined posttraumatic growth in 60 women seeking shelter from intimate partner violence. Cann and colleagues (2010) reported a coefficient alpha internal reliability estimate of .93 when researching posttraumatic growth among cancer patients ($n=72$). These researchers also reported a coefficient alpha internal reliability estimate of .90 when evaluating posttraumatic growth among 85 college students (Cann et al., 2010). In the current study, a Cronbach alpha of internal reliability estimate of .838 was observed.

Validity of the PTGI has been explored through confirmatory factor and correlational analyses. The confirmatory factor analysis conducted by Cann and colleagues (2010) supported a five factor structure of the PTGI-SF, which is identical to the five factor structure of the PTGI that was supported by the confirmatory factor analysis completed by Taku, Cann, Calhoun, and Tedeschi (2008). The five factor structure includes five dimensions of growth in the areas of relating to others, new possibilities, personal strength, spiritual change, and appreciation of life. In a study conducted by Calhoun, Cann, Tedeschi, and McMillan (2000), a significant association between posttraumatic growth and the degree of self-reported rumination soon after an event ($r = .57, p < .001$) was reported, indicating that the more a person ruminates and tries to make meaning after a traumatic event, the more likely that higher levels of posttraumatic growth would be observed. The results reported by Calhoun and colleagues (2000) are similar to the results in an earlier study by Tedeschi and Calhoun (1996) where people who reported experiencing severe trauma, as measured by the Traumatic Stress Schedule (Norris, 1980), also reported higher levels of posttraumatic growth (as measured by the PTGI). These results are in line with the theoretical conceptualization of posttraumatic growth which proposes that people who think more about a traumatic event and the event's significance and meaning are more likely to experience posttraumatic growth (Tedeschi & Calhoun, 1995; Tennen & Affleck, 1998).

Empathy. (Appendix B) The Jefferson Scale of Empathy for Health Professions Students (JSE-HP-S; Fields et al., 2011) was adapted from the Jefferson Physician Scale of Empathy (Hojat et al., 2002) to be used with students in healthcare professions. The

scale measures the student's ability to engage empathically with clients, which is defined as the ability to understand a client's experiences, the capability to communicate this understanding, and the ability to express their intention to help the client (Fields et al., 2011). The JSE-HP-S contains 20 items to which respondents answer with a 7-point Likert scale (1 = strongly disagree to 7 = strongly agree) and can be completed in 10 minutes. Ten of the items are negatively worded and require reverse scoring. The scores on the JSE-HP-S range from 20 to 140. Scores reflect the student's orientation or tendency to empathically engage with clients with higher scores indicating a higher tendency or greater ability to provide empathically oriented care (Hojat et al., 2002). For the purposes of this study, wording of the items on the JSE-HP-S were amended to be remove medical language and be more counselor friendly.

In a longitudinal study conducted with 265 nursing students, Fields and colleagues (2011) reported a Cronbach's alpha internal reliability estimate of .78 for the JSE-HP-S. The researchers reported test-retest reliability coefficient of .58 for 99 students who completed the scale after three months and .69 for 30 students who completed the scale after six months. This was the first study to utilize the JSE-HP-S to assess empathy in counselors in training. For the current study, a Cronbach alpha of internal reliability estimate of .792 was observed.

It is useful to also describe the reliability and validity of the Jefferson Physician Scale of Empathy (JPSE; Hojat et al., 2002) because the JSE-HP-S is based on and derived from the JPSE. Tavokol, Dennick, and Tavokol (2011) reported a Cronbach alpha internal consistency estimate of .76 from their study with 853 medical students.

Hojat, Mangione, Kane, and Gonnella (2005) in their study with 93 first year medical students reported total scores on the JPSE moderately correlated ($r = .45, p < 0.01$) with total scores on the Interpersonal Reactivity Index (IRI; Davis, 1980). The researchers also reported that higher correlations were observed between related factors of compassionate care and perspective taking on the JPSE with factors of empathic concern and perspective taking on the IRI than on other factors of personal distress and fantasy on the IRI (Hojat, Mangione, Kane & Gonnella, 2005). The JPSE has been utilized to measure empathy among counselors (Brockhouse et al., 2011; Linley & Joseph, 2007). Brockhouse and colleagues (2011) reported a Cronbach alpha coefficient of .77 in 118 therapists. Linley and Joseph reported a Cronbach alpha coefficient of .64 in their study with 156 therapists. Tavokol and colleagues (2011) completed a confirmatory factor analysis of the JPSE and reported a three-factor structure indicating empathy as a multidimensional construct. The researchers described the three factors of empathy as compassionate care, perspective taking, and emotional detachment. This is similar to the definition of empathy provided by Fields and colleagues (2011) as a measure of a nursing student's ability to understand a client's experience, having the ability to express understanding, and move forward with providing care.

Procedures

The researcher received approval from the Institutional Review Board (IRB) at the University of North Carolina at Greensboro. After receiving IRB approval and permission to proceed with the full study, the researcher emailed counselor education and supervision faculty at selected institutions that have received CACREP accreditation to

begin recruitment of student participants. The researcher contacted faculty and supervisors at 17 CACREP accredited graduate counseling institutions to recruit counselors in training for the study between November 2014, and February 2, 2015. Of those graduate institutions contacted, a total of 56 counselors in training started the research survey. After evaluating the sample through frequency tables it was discovered that only 41 counselors in training had completed the survey in its entirety. Among the 41 counselors in training who had completed the survey, six were ineligible due to not being in a clinical internship. After deleting incomplete responses and ineligible counselors in training, a total of 35 counselors in training were included in this research study.

The researcher emailed faculty that asked them to forward the researcher's invitation email to students currently enrolled in an internship. Counselors in training who chose to participate were directed to click on a link to the Qualtrics online survey, which was presented in three sections. The first section contained the informed consent outlining the participant's rights, procedures for maintaining confidentiality, potential risks as a participant in the study, and information about incentives (See Appendix A to review the informed consent). The second section contained the demographic questionnaire, the JSE-HP-S (Fields et al., 2011), the PTGI-SF (Cann et al., 2010), and the TABS (Pearlman, 2003). The demographic question pertaining to personal trauma history was presented after the standardized instruments so as not to influence participant's thoughts about trauma. All surveys were completed through the Qualtrics online survey software and secure website for academic research. In the third section, participants were asked if they were willing to participate in semi-structured interviews

and requested their email address. Participants were asked to provide their email address only for the purpose of recruiting participants for the semi-structured interviews and for distribution of incentives. (See Appendix B to review the Demographic Questionnaire and Standardized Instruments).

Each participant was assigned a study identification number, which was the only identifier during data analysis. Any and all participant identifying information was kept in a spreadsheet that remains separate from the participants' response data. All information has been kept confidential through the use of password protected computer files on a password protected computer. Access to identifying information was available only to the researcher for purposes of inviting the counselor in training to participate in semi-structured interviews. Access to data used for data analysis was available in aggregate form to the researcher and faculty member(s) who oversaw the research.

Data Analysis

Upon completing the data collection from Phase 1 of the study, the data was recorded and analyzed utilizing the Statistical Package for Social Sciences (SPSS) version 22. Prior to completing the data analyses for specified research questions, all data was first reviewed for any missing data, descriptive statistics were calculated, and reliability estimates were computed. Table 1 contains an outline of the research questions, hypotheses, constructs, and data analysis procedures for Phase 1 of the study.

The first research question (What are the levels of vicarious traumatization and posttraumatic growth among counselors in training?) addressed the presence of vicarious

traumatization and posttraumatic growth among counselors in training. Descriptive statistics were computed to determine the mean, median, mode, variance, standard deviation for the scores observed on the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010). Reliability estimates were also computed for the standardized measurements.

The second research question (How are the levels of vicarious traumatization and posttraumatic growth among counselors in training significantly differentiated by personal trauma history, amount of exposure, and number of supervision hours?) examined if there were significant group differences in the scores on the TABS (Pearlman, 2003) or the PTGI-SF (Cann et al., 2010) for the person characteristics *t*-tests were conducted to determine significant group differences in the person characteristics of having a personal trauma history, exposure to client trauma, and number of supervision hours received by counselors in training. According to G*Power (Version 3.1.7) a sample size of 34 participants was needed to obtain a moderate effect size with power of .80 to adequately compute the analyses.

The third research question (How does empathy and person characteristics found to be significant in research question one influence levels of vicarious traumatization and posttraumatic growth among counselors in training across time?) sought to examine if levels of vicarious traumatization and posttraumatic growth were influenced by empathy, personal trauma history, exposure to clients with a trauma history, or hours of supervision. Two hierarchical regressions were employed to evaluate the influence of the person characteristics found to be significant in research question two above and beyond

the influence of empathy on vicarious traumatization and posttraumatic growth. The addition of a person characteristic was determined based on the level of significance found in research question two. As the experience of personal trauma history is dichotomous it was dummy coded as 1 for “No” and 2 for “Yes”. Commonality analyses were then computed to determine the shared and unique variances of empathy and person characteristics in relation to vicarious traumatization and posttraumatic growth. The commonality analysis assisted in portioning out the regression effects into overlapping and non-overlapping parts (Nimon, 2010). In order to obtain a moderate effect size and power of .80, an estimated sample size of at least 55 when using one predictor (empathy) to at most 77 participants when entering and using all four predictors (empathy, personal trauma history, exposure to clients with a trauma history, hours of supervision) were needed to compute the hierarchical regression analyses according to G*Power (Version 3.1.7).

Phase 2: Qualitative Portion

Multiple Case Study

The current study implemented a case study as case study allowed for a “...deep understanding of particular instances of phenomena” of vicarious traumatization and posttraumatic growth (Mabry, 2009, p. 214). According to Yin (2003), a case study is an “...empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and context are not clearly evident” (p. 13). For the purpose of this study, the phenomenon of interest

included vicarious traumatization, posttraumatic growth, and the proximal process counselors in training experience when they empathically engage with clients.

As previously discussed, it is unclear what aspects of the intimate interactions involved in the proximal process between counselors in training and their clients impacts counselors in training. In addition, there is limited information about how counselors in training experience vicarious traumatization and posttraumatic growth. To achieve this deep understanding, a multiple case design with theoretical replication logic was employed to aid in purposeful selection of counselors in training. The theoretical replication logic allowed for exploration of cases that were predicted to have contrasting findings for anticipated reasons (Yin, 2014). In the current study, the anticipated differences were that levels of vicarious traumatization and posttraumatic growth would be dissimilar. Specifically, the differing levels included high levels of both vicarious traumatization and posttraumatic growth, low levels of both vicarious traumatization and posttraumatic growth, high levels of vicarious traumatization and low levels of posttraumatic growth, or low levels of vicarious traumatization and high levels of posttraumatic growth. Eight cases were purposefully selected based on their observed scores on the TABS (Pearlman, 2003) and PTGI-SF (Cann et al., 2010). In employing a multiple case study, counselors in training were able to give voice, provide context, and add to the discussion of the phenomena of interest in this study.

Sample and Participant Selection

Only participants who had completed the entire survey in Phase 1, consented to participate in both phases of the study, and enrolled as a master's level graduate

counseling student in an internship at a graduate institution that has CACREP accreditation were eligible to participate in Phase 2 of the study. From this sampling pool, the researcher identified 22 participants whose scores on the TABS (Pearlman, 2003) and PTGI-SF (Cann et al., 2010) ranged from below the study average to above the study average on the measure of vicarious traumatization ($N = 35$, $M = 171.5$, $SD = 35.36$) and posttraumatic growth ($N = 35$, $M = 28$, $SD = 9.04$). The researcher emailed 12 counselors in training that expressed willingness to participate in Phase 2 and invited them to take part in a semi-structured interview. Eight counselors in training agreed to participate in the semi-structured interview. The participants selected the day and time of the interview, and selected the interview be conducted via telephone, Skype, or Google Hangout. All eight of the counselors in training asked their interview to be conducted on the telephone. Through this purposeful selection of participants, the researcher was able to illuminate and explain observed scores of vicarious traumatization and posttraumatic growth among counselors in training. In addition, the researcher added depth to further understand how counselors in training experience the proximal process of working with traumatized clients.

Each participant who completed a semi-structured interview was assigned a study identification number and a pseudonym at the time of within case analysis, which were the only identifiers during data analysis. Any and all participant identifying information was kept in a spreadsheet that remained separate from the participants' response data. All information has been kept confidential through the use of password protected computer files on a password protected computer. Access to identifying information was

available only to the researcher for purposes of inviting the counselor in training to participate in semi-structured interviews and distribution of incentives.

Procedures

In order to limit researcher bias and help maintain researcher objectivity, the researcher wrote a bracketing and reflexive memo that she read prior to conducting each semi-structured interview. In the bracketing memo the researcher included an evaluation of personal issues related to undertaking this research study; any cultural assumptions or biases related to researcher's race, gender, age, and socioeconomic status; a recognition of the power differential inherent in working with counselors in training; described potential areas for conflicts of role; and clarified any value systems or areas where she may be subjective (Ahern, 1999). In addition, the researcher kept a reflexive and field journal throughout the study to keep track of notes or feelings that indicated a lack of objectivity. The researcher completed field journal entries before and after each semi-structured interview to address and clarify anything that might influence analysis of the interview. In the event the researcher felt she was losing objectivity, she revisited the bracketing memo, reflexive journal, and consulted with her research advisor.

The researcher emailed a reminder to the participant within 24 hours of the scheduled interview along with a copy of the participant's graphical and written results from the repeated measures completed during Phase 1 of the study. The semi-structured interview contained ten questions with probes and was completed within 60 minutes (Appendix C). During the semi-structured interview, participants were asked to respond to questions pertaining to their results from Phase 1 of the study. The questions and

probes were related to the fourth research question (How do counselors explain the change or lack of change that occurred in the repeated administrations of the measures for vicarious traumatization and posttraumatic growth?). Participants will also receive questions and probes to gather information pertaining to possible experiences of the proximal process of counseling clients who have experienced trauma. This is related to the fifth research question (How do counselors in training describe their experiences within the proximal process of providing counseling services to clients who have experienced trauma?). (See Appendix C to review the Semi-Structured Interview guide.) After completing each semi-structured interview the researcher completed a field journal entry with general impressions, any common theme(s) that emerged during the interview, and noted any surprises or unexpected responses.

All semi-structured interviews were audio recorded and transcribed verbatim. The researcher transferred audio recordings to a password protected file on a password protected computer within 24 hours after the semi-structured interview was completed. Each semi-structured interview was transcribed within 72 hours after the semi-structured interview was conducted. The transcriptions do not contain any personal identifying information. After an interview was completely transcribed, it was checked for accuracy with the audio recording and then deleted from the digital recording device. This process was repeated for each transcribed interview.

Data Analysis

Once all interviews were completed, transcribed, and verified for accuracy, the researcher will begin analyzing the qualitative data. The researcher utilized multiple case

study methodology to analyze the qualitative data obtained during the semi-structured interviews along with the answers to open-ended and forced-choice questions obtained from surveys completed in Phase 1 of the study. A within-case analysis was implemented to provide a detailed description and note any specified themes of each case (Creswell, 2013). After completing the within-case analysis, a cross-case analysis was implemented to review and link common themes (Creswell, 2013). (See Table 2 for the data analysis plan for Phase 2, qualitative portion of the study.)

To begin the within-case analysis, the researcher made a preliminary exploration of the data by reading through the transcribed interview and writing initial notes on the transcript. Next, the researcher separated the text into coding segments that were labeled by codes based on the thematic content. The qualitative data was coded utilizing the qualitative data analysis software NVivo (for Mac, Version 10.1.3). The researcher consulted her bracketing memo and field journal entries for additional information. After the within-case analysis is completed and accuracy was verified, the researcher completed a cross-case analysis that highlighted the similarities and differences between the cases. The researcher then utilized an auditor who reviewed the coding segments and provided feedback regarding segments that did not match the theme. The researcher then modified and amended the coding based on auditor feedback.

Table 2

Data Analysis Plan for Phase 2: Qualitative Portion

Research Question	Data Analysis
RQ4: How do counselors explain the change or lack of change that occurred in the repeated administrations of the measures for vicarious traumatization and posttraumatic growth?	Thematic coding Within and cross case analysis
RQ5: How do counselors in training describe their experiences within the proximal process of providing counseling services to clients who have experienced trauma?	Thematic coding Within and cross case analysis

The credibility and trustworthiness of the findings presented was validated through use of constant comparison, triangulation of multiple sources of information, reviewing and resolving any disconfirming evidence, and ongoing auditing by the researcher's advisor (Creswell, 2013; Creswell & Piano, 2011; Heppner & Heppner, 2004).

The final data analysis integrated and connected the quantitative data with the qualitative findings of the study. The goal was to discuss how the qualitative findings helped explain the quantitative results. In connecting the quantitative results with the qualitative findings, additional information about vicarious traumatization and posttraumatic growth among counselors in training was illuminated.

CHAPTER IV

RESULTS

Introduction

This chapter provides a detailed description of the counselors in training and provides results of the statistical analyses performed to address the hypotheses presented in the previous chapters. All data collected for this study was obtained from master's level counselors in training at institutions that are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). This chapter is organized in two sections. The first section will provide an overview of the quantitative data and sampling information conducted in Phase 1. The second section will provide an overview of the qualitative results and sampling information obtained in Phase 2 of the study.

Phase 1: Quantitative Portion

Description of Sample

Thirty-five counselors in training participated in the study. The majority resided in North Carolina (54.3%), with five other states being represented (Table 3). Counselors in training were predominantly female ($n = 31$; 88.6%), with an average age of 28.77 years ($SD = 8.01$; range 22 to 60 years). In addition, the majority of counselors in training were of non-Hispanic/Latino ethnicity (88.6%) and self-identified as white or Caucasian (88.6%), followed by Black or African American (5.7%) and American Indian/Alaskan

Native and Biracial (2.9% each; Table 4). In examining the relationship status, counselors in training were primarily in dating relationships (31.4%), married without children (20%), single or partnered without children (17.1%; Table 4).

Table 3

Regional Demographics of Sample in Phase 1

State	Frequency	Percentage
Arizona	5	14.3
North Carolina	19	54.3
North Dakota	3	8.6
Ohio	3	8.6
Oregon	2	5.7
Texas	3	8.6
Total	35	100

Table 4

Gender, Racial/Ethnicity, Relationship Demographics of Sample in Phase 1

Demographic Variable	Frequency	Percentage
<u>Gender</u>		
Female	31	88.6
Male	4	11.4
<u>Ethnicity</u>		
Hispanic/Latino	4	11.4
Not Hispanic/Not Latino	31	88.6

Table 4 (Continued)

Gender, Racial/Ethnicity, Relationship Demographics of Sample in Phase 1

Demographic Variable	Frequency	Percentage
<u>Race</u>		
American Indian/Alaskan Native	1	2.9
Black or African American	2	5.7
White/Caucasian	31	88.6
Native Hawaiian/Other Pacific Islander	0	0.0
Black/African American and White/Caucasian	1	2.9
<u>Relationship Status</u>		
Single	6	17.1
Dating	11	31.4
Partnered w/ Children	0	0.0
Married w/o Children	7	20.0
Married w/ Children	3	8.6
Divorced	2	5.7
Widowed	0	0.0

Note. $N = 35$ counselors in training.

Over half of the counselors in training were currently enrolled in an MS degree counseling program ($n = 20$, 57.1%), followed by MEd degree program ($n = 12$; 34.3%), an MC degree program ($n = 2$; 5.7%), and a M.Ed. degree program ($n = 1$; 2.9%). A majority of counselors in training reported attending school full time ($n = 32$; 91.4%) with only a few attending part-time ($n = 3$; 8.6%). Most had completed more than 31 credit hours ($n = 33$; 94.3%) of their educational program and 2 (5.7%) had completed 21 to 30 credit hours. A variety of counseling tracks were represented, with a majority specializing in clinical mental health counseling track ($n = 19$; 54.3%), followed by

34.2% in the school counseling track ($n = 12$), and 11.4% each in the marriage, couple, and family track ($n = 4$), and the student affairs and college counseling track ($n = 4$).

The counselors in training indicated a variety of settings for their clinical internship with most of them in an outpatient setting ($n = 12$; 34.3%) or school setting ($n = 10$; 28.6%; Table 5). A majority of the clients seen by counselors in training at their internship were young adults between the ages of 18 to 24 years (51.4%), followed by adults and adolescents (45.7%), and school aged children (31.4%). The counselors in training had an average of 15.66 ($SD = 9.82$) clients on their caseload for clinical internship (Table 6). All 35 counselors in training reported having clients on their caseload with a history of trauma. The average number of clients with a history of trauma on a counselor in training's caseload was 7.31 ($SD = 6.32$). On average, 49% ($SD = 28\%$) of clients on the caseloads of counselors in training had experienced some form of trauma (Table 6). Counselors in training described their clients as having multiple traumas with the most frequently reported traumas including childhood physical abuse (68.6%), childhood sexual abuse (51.4%), divorce (48.6%), date rape (43.9%), and domestic violence (34.3%; Table 7).

Table 5

Clinical Internship Setting and Population for Sample in Phase 1

Setting and Population Variable	Frequency	Percentage
<u>Internship Setting</u>		
College	7	20.0
School	10	28.6
Outpatient	12	34.3
Intensive Outpatient	2	5.7
<u>Internship Setting</u>		
Inpatient	1	2.9
Community YWCA	1	2.9
Community Based	1	2.9
Oncology Unit in Hospital	1	2.9
<u>Population Served^a</u>		
Young Children (ages 2-4)	3	8.6
School Aged Children (ages 5-11)	11	31.4
Adolescents (ages 12-18)	16	45.7
Young Adults (ages 18-24)	18	51.4
Adults (ages 25-64)	16	45.7
Older and Elderly Adults (ages 65 +)	3	8.6

Note: ^a Counselors in training worked with more than one population.

Table 6

Caseload Information for the Sample in Phase 1

Caseload	Mean	SD	Minimum	Maximum
Total Number of Clients on Caseload	15.66	9.82	4	41
Total Number of Clients on Caseload w/ Trauma History	7.31	6.32	2	26
Exposure to client trauma ^a	.49	.28	.17	1.00

Note. ^aExposure to client trauma was calculated by dividing total caseload by total number of clients on the caseload with a history of trauma.

Table 7

Types of Trauma on Caseload for the Sample in Phase 1

Type of Trauma	Frequency	Percentage ^a
Automobile Accident	7	20.0
Childhood Physical Abuse	24	68.6
Childhood Sexual Abuse	18	51.4
Childhood Neglect	3	8.6
Date Rape	15	42.9
Death of a Loved One	10	28.6
Diagnosis of a Disease or Disability	9	25.7
Divorce	17	48.6
Domestic Violence	12	34.3
Homelessness	1	2.9
Miscarriage	3	8.6
Military Combat or Warzone	2	5.7
Moving	10	28.6
Natural Disaster	1	2.9
Parent Deported	1	2.9
Physical Assault	7	20.0
Rape	11	31.4
Robbery	1	2.9
Torture	1	2.9

Note: ^a Counselors in training had clients on the caseload with a history of more than one trauma.

The counselors in training reported receiving supervision weekly for an average of 2.43 hours ($SD = .85$). All counselors in training reported receiving supervision from a combination of university supervisors ($n = 19$; 54.3%), university doctoral supervisors ($n = 14$; 40%), and internship site supervisors ($n = 34$; 97.1%). The format of supervision included individual ($n = 29$; 82.9%), group ($n = 27$; 77.1%), and triadic ($n = 6$; 17.1%).

Of the 35 counselors in training, 68.6% ($n = 24$) reported having experienced at least one personal trauma, while 31.4% ($n = 11$) reported no history of personal trauma.

Of those counselors who reported a history of personal trauma, they reported

experiencing an average of 1.31 ($SD = 0.47$) personal traumas. The counselors in training most frequently reported personal trauma that included death of a loved one (37.1%), divorce (25.7%), and automobile accidents (20%).

Table 8

Personal Trauma History for the Sample in Phase 1

Type of Personal Trauma Experienced ^a	Frequency	Percentage
Automobile Accident	7	20.0
Childhood Emotional Abuse	3	8.6
Childhood Neglect	1	2.9
Childhood Physical Abuse	2	5.7
Childhood Sexual Abuse	2	5.7
Date Rape	2	5.7
Death of a Loved One	13	37.1
Diagnosis of a Disease or Disability in Self	5	14.3
Diagnosis of a Disease in Loved One	1	2.9
Divorce	9	25.7
Domestic Violence	2	5.7
Miscarriage	1	2.9
Military Combat or War zone	1	2.9
Physical Assault	3	8.6
Rape	3	8.6
Other: Exposure to Substance Abuse in childhood home	1	2.9
Other: Vicarious Trauma	1	2.9

Note: $N = 35$. ^a Counselors in training reported experiencing more than one personal trauma.

Data Analysis

Prior to analyzing any of the research questions, all variables were checked to ensure they met statistical assumptions. The mean, standard deviation, and psychometric information for each of the measures are provided in Table 9. The researcher examined

the skewness and kurtosis to evaluate the normality of distribution for the variables of personal trauma history, hours of supervision, exposure to client trauma, and the scores on the standardized instruments for empathy (JSE-HP-S; Fields, et.al., 2011), vicarious traumatization (TABS; Pearlman, 2003), and posttraumatic growth (PTGI-SF; Cann et al., 2010). All variables were observed to have values of less than two for skewness indicating a symmetrical and normal distribution. In evaluating for kurtosis, or the flatness or peakedness of the distribution, all but empathy followed a mesokurtic or normal distribution. The variable of empathy demonstrated a leptokurtic distribution with scores concentrated around the mean indicating that most of the counselors in training who participated in the study demonstrated an average level of empathy. In addition the researcher assessed for missing data. On the TABS (Pearlman, 2003), two counselors in training had missing data for six items and per the assessment manual, the missing scores were replaced with the mean score for that question.

Table 9

Descriptive Statistics

Instrument	Mean	Standard Deviation	Minimum	Maximum	Cronbach alpha
JSE-HP-S	117.71	10.37	80.0	137.0	.79
PTGI-SF	28.0	9.04	0.00	44.0	.84
TABS	171.51	35.36	103.00	256.00	.95

Note: N = 35. JSE-HP-S is the Jefferson Scale of Empathy for Health Professions Student (JSE-HP-S; Fields, et.al., 2011). PTGI-SF the Posttraumatic Growth Inventory-Short Form (PTGI-SF; Cann et al., 2010). TABS refers to the Trauma and Attachment Beliefs Scale (TABS; Pearlman, 2003).

Research Question 1. The first research question (What are the levels of vicarious traumatization and posttraumatic growth among counselors in training?) addressed the presence of vicarious traumatization and posttraumatic growth among counselors in training. The counselors in training exhibited levels of both vicarious traumatization and posttraumatic growth. Counselors in training ($N = 35$) were observed to have a mean score of 171.51 ($SD = 35.36$) and scores ranged from 103 to 256 on the TABS (Pearlman, 2003). Based on these scores, the counselors in training exhibited levels of vicarious traumatization that ranged from very low to very high, with the average score ($M = 171.51$; $SD = 35.36$) indicating that most counselors in training who participated in the study exhibited an average level of vicarious traumatization. In examining posttraumatic growth, as measured by the PTGI-SF (Cann et al., 2010), counselors in training scored a mean of 28.0 ($SD = 9.04$), indicating a small to moderate degree of change since beginning to see clients. The minimum score observed was 0.00, indicating no change or growth since beginning clients. The maximum score obtained was 44.0, indicating a great degree of change and growth since beginning to see clients. The descriptive and reliability statistics are reported in Table 9.

Research Question 2. The second research question (How are the levels of vicarious traumatization and posttraumatic growth among counselors in training significantly differentiated by personal trauma history, amount of exposure, and number of supervision hours?) explored for any significant differences on scores of vicarious traumatization and posttraumatic growth among counselors in training based on having a history of personal trauma, exposure to clients with a trauma history, and number of

supervision hours received. According to G*Power (Version 3.1.7) a sample size of 34 participants was recommended to obtain a moderate effect size with power of .80 to adequately compute the *t*-test analyses.

Vicarious Traumatization. In order to determine if there was a significant difference on the scores on the TABS (Pearlman, 2003), which measured vicarious traumatization, *t*-tests were computed for personal trauma history, exposure to clients with a trauma history, and supervision hours (Table 10). Post hoc analysis were computed in G*Power (Version 3.1.7) to verify power.

Personal Trauma History. There was no significant difference observed in scores on vicarious traumatization for counselors in training with a personal history of trauma ($n = 24$, $M = 170.71$, $SD = 32.46$) compared to counselors in training who reported no history of personal trauma ($n = 11$, $M = 173.27$, $SD = 42.68$; $t(33) = -.196$, $p = .423$). The magnitude of the difference in the means (mean difference = -2.56, 95% *CI*: -29.13 to 24.00) was very small (Cohen's $d = .071$). A post hoc analysis was computed and power of .070 was observed.

Exposure to Client Trauma. No significant difference was found in scores on vicarious traumatization for counselors in training exposed to a caseload of at least 49% or greater with clients having a history of trauma ($n = 16$, $M = 174.13$, $SD = 32.84$) compared to counselors in training whose caseload contained less than 49% of clients with a history of trauma ($n = 19$, $M = 169.32$, $SD = 38.09$; $t(33) = .396$, $p = .348$). The magnitude of the difference in the means (mean difference = 4.81, 95% *CI*: -19.91 to

29.52) was small (Cohen's $d = .134$). A post hoc analysis was computed and power of .121 was observed.

Hours of Supervision. Counselors in training who received at least 2.5 hours or more of weekly supervision were compared to counselors in training who received less than 2.5 hours of supervision. There was a significant difference in scores on vicarious traumatization for counselors in training who received at least 2.5 hours or more of weekly supervision ($n = 15$, $M = 157.73$, $SD = 33.37$) compared to counselors in training received less than 2.5 hours of weekly supervision ($n = 20$, $M = 181.85$, $SD = 33.97$; $t(33) = -2.09$, $p = .022$). The magnitude of the difference in the means (mean difference = -24.12, 95% *CI*: -47.55 to -.69) was medium to large (Cohen's $d = .715$). A post hoc analysis was computed and power was calculated as .984. Of the personal variables assessed in relation to vicarious traumatization, only the hours of supervision was observed to yield significant results ($t(33) = -2.094$, $p = .022$).

Table 10

t-test Analyses Summary for Vicarious Traumatization

	<i>n</i>	Mean	Standard Deviation	<i>t</i>	Sig. (1-tailed)
<u>Personal Trauma History</u>					
Yes	24	170.71	32.46	-.196	.423
No	11	173.27	42.68		
<u>Exposure to Client Trauma</u>					
> = 49%	16	174.13	32.84	.396	.348
< 49%	19	169.32	38.09		
<u>Hours of Supervision</u>					
> = 2.5 hours	15	157.73	33.37	-2.094	.022*
< 2.5 hours	20	181.85	33.97		

Note. *N* = 35. * *p* < .05

Posttraumatic Growth. The 35 counselors in training who participated in the current research study demonstrated an average total score of 28 (*SD* = 9.04) on the PTGI-SF (Cann et al., 2010). In order to determine if there was a significant difference on the scores of posttraumatic growth, independent *t*-tests were computed for personal trauma history, exposure to clients with a trauma history, and supervision hours (Table 11). Post hoc analysis were computed in G*Power (Version 3.1.7) to verify power.

Personal Trauma History. No significant difference was found in scores on the PTGI-SF (Cann et al., 2010) for counselors in training with a personal history of trauma (*n* = 24, *M* = 29.29, *SD* = 6.97) compared to counselors in training who reported no history of personal trauma (*n* = 11, *M* = 25.18, *SD* = 12.38; *t* (33) = 1.26, *p* = .109). The magnitude of the difference in the means (mean difference = 4.11, 95% *CI*: -2.53 to

10.75) was moderate (Cohen's $d = .459$). A post hoc analysis was computed and power of .751 was observed.

Exposure to Client Trauma. There was a significant difference in scores on posttraumatic growth for counselors in training exposed to a caseload of at least 49% or greater with clients having a history of trauma ($n = 16, M = 30.75, SD = 6.50$) compared to counselors in training whose caseload contained less than 49% of clients with a history of trauma ($n = 19, M = 25.68, SD = 10.33; t(33) = 1.697, p = .0495$). The magnitude of the difference in the means (mean difference = 5.07, 95% *CI*: -1.01 to 11.14) was moderate (Cohen's $d = .575$). A post hoc analysis was computed and power of .911 was observed.

Hours of Supervision. There was a not significant difference in scores on the PTGI-SF (Cann et al., 2010) for counselors in training who received at least 2.5 hours or more of weekly supervision ($n = 15, M = 26.73, SD = 11.07$) compared to counselors in training received less than 2.5 hours of weekly supervision ($n = 20, M = 28.95, SD = 7.32; t(33) = -.713, p = .241$). The magnitude of the difference in the means (mean difference = -2.22, 95% *CI*: -8.54 to 4.11) was small (Cohen's $d = .244$). A post hoc analysis was computed and power of .289 was observed.

Table 11

t-test Analyses Summary for Posttraumatic Growth

	<i>n</i>	Mean	Standard Deviation	<i>t</i>	Sig. (1-tailed)
<u>Personal Trauma History</u>					
Yes	24	29.29	6.97	1.360	.109
No	11	25.18	12.38		
<u>Exposure to Client Trauma</u>					
> = 49%	16	30.75	6.50	1.697	.0495*
< 49%	19	25.68	10.33		
<u>Hours of Supervision</u>					
> = 2.5 hours	15	26.73	11.07	-.713	.241
< 2.5 hours	20	28.95	7.32		

Note: *N* = 35. * *p* < .05

Research Question 3. The third research question (How do empathy and person characteristics found to be significant in research question two influence levels of vicarious traumatization and posttraumatic growth among counselors in training across time?) sought to examine if levels of vicarious traumatization and posttraumatic growth are influenced by empathy and any of the person characteristics (personal trauma history, exposure to client trauma, and hours of supervision) found to be significant in research question two. To determine the influence of these factors hierarchical multiple regressions were computed for vicarious traumatization and posttraumatic growth.

Vicarious Traumatization. A two-step hierarchical multiple regression was conducted with vicarious traumatization as the dependent variable. According to the a priori power analyses computed in G*Power (Version 3.1.7), a sample size of at least 68 counselors in training would be needed to achieve .80 power and a moderate effect size.

Preliminary data analyses were conducted to ensure assumptions of normality, linearity, and homoscedasticity were not violated. The collinearity statistics did not indicate multicollinearity (Tolerance = .883; VIF = 1.132). Additionally, the correlations between empathy and hours of supervision were evaluated to ensure they were not highly correlated ($r = .341, p < .05$). This indicates that multicollinearity was unlikely to be a problem (Tabachnick & Fidell, 2007).

Empathy was entered into the first step of the hierarchical multiple regression. In the second step or block, hours of supervision was entered as it was the only person variable found to have significant group differences in research question two. In the first step, empathy accounted for a 32% of variance in vicarious traumatization ($R^2 = .322$) and the model was statistically significant ($F(1, 33) = 15.680, p < .05$). In the second step, when hours of supervision was added, the model accounted for additional variance (R^2 change = .010) after controlling for the variance explained by empathy. The full model was significant ($F(2, 32) = 7.946, p < .05$) indicating that together, empathy and hours of supervision accounted for 33% of the variance in vicarious traumatization as measured by the TABS (Pearlman, 2003). A post hoc power analysis was computed with medium effect size ($f^2 = .497$) and the observed statistical power was calculated to be .954. The summary of the hierarchical regression analyses for vicarious traumatization is in Table 12.

Table 12

Hierarchical Regression Analyses for Vicarious Traumatization

	R^2	ΔR^2	B	SE	β	t
Step 1	.322*					
Empathy			-.1.936	.489	-.568	-3.96*
Step 2	.332**	.010				
Empathy			-1.814	.524	-.532	-3.46**
Hours of Supervision			-4.363	6.394	-.105	-.682

Note. $N = 35$. Statistical significance: * $p < .001$; ** $p < .01$.

The total variance of vicarious traumatization explained by the hierarchical multiple regression model was 33.2%. A commonality analysis was conducted to determine the amount of predicted variance that was shared among and unique to empathy and hours of supervision. Results indicated that the two variables shared 7.2% of the variance in vicarious traumatization. Empathy uniquely explained 25% of the variance, which was significant as indicated by previous analysis. Hours of supervision uniquely explained 1% of the variance, which was non-significant as a predictor of vicarious traumatization, but was found to be significant in differentiating levels of vicarious traumatization for trainees who had greater and less than 2.5 hours of weekly supervision.

Posttraumatic Growth. A two-step hierarchical multiple regression was conducted with vicarious traumatization as the dependent variable. According to the a priori power analyses computed in G*Power (Version 3.1.7), a sample size of at least 68 counselors in training would be needed to achieve .80 power and a moderate effect size.

Preliminary data analyses were conducted to ensure assumptions of normality, linearity, and homoscedasticity were not violated. The collinearity statistics did not indicate multicollinearity (Tolerance = .955; VIF = 1.047). Additionally, the correlations between empathy and exposure to client trauma were evaluated to ensure they were not highly correlated ($r = .213, p > .05$). This indicates that multicollinearity was unlikely to be a problem (Tabachnick & Fidell, 2007).

Empathy was entered into the first step of the hierarchical multiple regression. In the second step or block, exposure to client trauma was entered as it was the only person variable found to have significant group differences in research question two. In the first step, empathy accounted for 0.2% of the variance in posttraumatic growth ($R^2 = .002$) and the model was not significant ($F(1, 33) = .062, p = .805$). In the second step, when exposure to client trauma was added, the model accounted for additional variance (R^2 change = .033) after controlling for the variance explained by empathy. The full model was not significant ($F(2, 32) = .574, p = .569$) indicating that together, empathy and exposure to client trauma do not significantly influence the level of posttraumatic growth as measured by the PTGI-SF (Cann et al., 2010). A post hoc power analysis was computed with small effect size ($f^2 = .036$) and the observed statistical power was calculated to be .147. Based on this analysis the power was not adequate, thus the potential for a Type II error is possible, due to small effect size and small sample size. The summary of the hierarchical regression analyses for vicarious traumatization is in Table 13.

Table 13

Hierarchical Regression Analyses for Posttraumatic Growth

	R^2	ΔR^2	B	SE	β	t
Step 1	.002					
Empathy			-.038	.152	-.043	-.249
Step 2	.035	.033				
Empathy			-.072	.155	-.083	-.466
Exposure to Client trauma			5.947	5.708	.185	1.042

Note. $N = 35$.

Phase 2: Qualitative Portion

The second phase of the study consisted of semi-structured interviews with eight counselors in training. The interviews were transcribed by the researcher and within case and cross case analyses were completed. Thematic coding was first completed for each case noting themes and patterns that emerged from the semi-structured interviews. After completing thematic coding for each case, the researcher completed cross case analyses that included comparing and contrasting themes and evaluating relationships between themes. The validity of the qualitative analyses was evaluated through triangulation of multiple data sources, auditing, and the researchers bracketing memo and reflective journal entries.

Description of Sample

Eight counselors in training, whose scores ranged from below the study average to above the study average on measures of vicarious traumatization ($N = 35$, $M = 171.5$, $SD = 35.36$) and posttraumatic growth ($N = 35$, $M = 28$, $SD = 9.04$), participated in the semi-structured interviews. Three had higher than average levels of vicarious

traumatization and posttraumatic growth (Ann: TABS = 173, PTGI-SF = 31; Ivy: TABS = 186, PTGI-SF = 33; Francine: TABS = 256, PTGI-SF = 40; see Table 13). Two demonstrated higher than average levels of vicarious traumatization and lower than average posttraumatic growth (Brooke: TABS = 210, PTGI-SF = 23; Celia TABS = 204, PTGI-SF = 27). Two others were observed to have lower than average levels of vicarious traumatization and posttraumatic growth (Georgia: TABS = 124, PTGI-SF = 23; Holly TABS = 103, PTGI-SF = 17). One demonstrated lower than average levels of vicarious traumatization and higher than average levels of posttraumatic growth (Dee: TABS = 129, PTGI-SF = 33). Additional information is provided in Table 14.

Table 14

Demographics of Counselors in Training in Phase 2

Counselor In Training	Age	Case-load	Clients w/ trauma	Empathy ^a _b	VT	PTG
High VT and High PTG						
Ann	27	25	10	123	173	31
Ivy	35	5	3	121	186	33
Francine	24	11	1	80	256	40
High VT and Low PTG						
Brooke	37	20	4	109	210	23
Celia	23	14	4	123	206	27
Low VT and Low PTG						
Georgia	52	25	20	112	123	23
Holly	36	16	6	127	103	17
Low VT and High PTG						
Dee	27	5	1	118	129	33

Note. VT = Vicarious traumatization as measured by the TABS (Pearlman, 2003). PTG = Posttraumatic growth as measured by the PTGI-SF (Cann et al., 2010). ^aEmpathy was measured by the JSE-HP-S (Fields, et.al., 2011). ^b The average score on the JSE-HP-S for the study was 117.71 ($SD = 10.37$).

High Vicarious Traumatization and High Posttraumatic Growth.

Ann (high/high). Ann is a 27 year old, non-Hispanic, Caucasian female who is completing requirements for a MS Ed degree with clinical mental health counseling specialization. She is married without children and attends school full time in North Carolina. Ann has completed more than 31 credit hours toward her degree. She is completing her internship at an outpatient counseling agency where she works with adults whose ages range from 25 to 64 years. Ann has a caseload of 25 clients of which 10 have a reported history of trauma. The trauma experiences of her clients include childhood

neglect, childhood physical and sexual abuse, death of a loved one, divorce, domestic violence, miscarriage, military combat, and rape. Ann reported receiving a weekly average of three hours of supervision from a university faculty supervisor and site supervisor in the format of individual and group sessions. Ann reported a personal trauma experience of emotional abuse in her family of origin.

Ivy (high/high). Ivy is a non-Hispanic, Caucasian female of 35 years who lives in North Carolina and described her relationship status as dating. She attends school full time and has completed more than 31 credit hours toward her MS degree with a specialization in clinical mental health counseling. Ivy is completing her internship at a community outpatient and residential agency where she has provided counseling services to youth and adolescents between the ages of six to 17 years. She has five clients on her caseload of which three have a reported history of trauma that includes childhood physical abuse, death of a loved one, moving, automobile accident, and divorce. Ivy reported receiving an average of two hours of supervision on a weekly basis from a university doctoral supervisor and site supervisor in the formats of individual and group. Ivy reported personal trauma experiences that included the death of a loved one and automobile accident. Ivy did not discuss these personal trauma experiences during the interview but did share a story about supporting a close friend when the friend's marriage "imploded" and that this experience challenged her views and beliefs.

Francine (high/high). Francine is a 24 year old, non-Hispanic, Caucasian, female who lives in North Dakota and is partnered without children. She attends school full time and has completed more than 31 credit hours toward her MS ED degree with a

specialization in clinical mental health counseling. Francine is completing her internship at a college counseling center and provides services to young adults. Her caseload includes 11 clients of whom one has reported a history of childhood physical abuse and neglect. During the interview, Francine also shared she had a client who had experienced rape. Francine reported receiving an average of two hours of individual supervision weekly from a university faculty supervisor and site supervisor. Francine reported no personal experiences of trauma.

High Vicarious Traumatization and Low Posttraumatic Growth.

Brooke (high/low). Brooke is an African American female of 37 years, is divorced, and resides in North Carolina. She attends graduate school full time and has completed more than 31 credit hours toward her MS degree in marriage, couple, and family counseling. Brooke is completing her internship in an outpatient setting where she provides services to a caseload of 20 adult clients. Of the 20 clients on her caseload, four reported a history of trauma that includes automobile accident, childhood physical abuse and neglect, and miscarriage. Brooke reported receiving an average of two hours of weekly supervision from a university doctoral supervisor and site supervisor in individual and group formats. Brooke reported personal trauma experiences of automobile accident, date rape, death of a loved one, diagnosis of a disease or disability, divorce, domestic violence, and miscarriage.

Celia (high/low). Celia is a 23 year old, single, non-Hispanic, Caucasian, female attending school in North Carolina. Celia attends school full time and has completed between 21 to 30 credit hours toward her degree requirements for a M.S. and Ed.S. with a

school counseling specialty. Celia has two internship sites; one where she works with children whose ages range from two to 11 years; and one where she works in a high school with adolescents whose ages range from 12 to 18 years. As a school counselor, Celia viewed every student in the school as part of her potential caseload. When considering the number of individual students she provided services to, Celia reported a caseload of 14 students. Of the students she met with individually, Celia stated that the four had trauma histories that included childhood neglect, death of a loved one, diagnosis of a disease or disability, divorce, moving, and having a parent deported. Celia reported receiving two hours of weekly supervision from a university supervisor and site supervisor in the formats of individual, group, and triadic. Celia reported personal trauma experiences of childhood neglect, death of a loved one, domestic violence and vicarious trauma.

Low Vicarious Traumatization and Low Posttraumatic Growth.

Georgia (low/low). Georgia is a Hispanic/Latina, white female living in North Carolina. She is 52 years of age and is married without children. Georgia attends graduate school full time and has completed between 21 to 30 credit hours toward her MS Ed. degree with a specialization in marriage, couples, and family counseling. While at her internship in a community mental health agency, Georgia provides counseling primarily to adult clients whose ages range from 25 to 64 years and has also provided counseling to a few school aged children. Georgia has a caseload of 25 clients of which 20 have reported a trauma history that includes automobile accidents, childhood physical and sexual abuse, death of a loved one, divorce, and domestic violence. Throughout the

week, Georgia reported receiving an average of two hours of supervision from her university doctoral supervisor and site supervisor. Georgia reported having personal trauma experiences that included the deaths of three close family members.

Holly (low/low). Holly is a single, 36 year old non-Hispanic, Caucasian female who resides in Arizona. She has completed more than 31 hours towards her MS degree in clinical mental health counseling. Holly provides services to patients on the adult and pediatric units at a hospital oncology department. She has a caseload of 16 clients of which five have reported a history of trauma that includes automobile accident, childhood physical and sexual abuse, death of a loved one, and diagnosis of a disability. On the survey, Holly listed only five clients as having a history of trauma despite all of her clients have a diagnosis of cancer. Holly reported receiving an average of three hours of individual and group supervision weekly from her site supervision. Holly listed multiple personal trauma experiences on her survey that included automobile accident, childhood physical and sexual abuse, date rape, death of a loved one, diagnosis of a disability or disease, divorce, physical assault, and rape. Holly did not share or discuss her personal trauma experiences during the interview.

Low Vicarious Traumatization and High Posttraumatic Growth.

Dee (low/low). Dee is a non-Hispanic, Caucasian female of 27 years who is dating and resides in North Carolina. Dee has completed more than 31 credit hours toward her MS Ed. counseling degree with a dual specialty of school counseling along with student affairs and college counseling. She is currently completing internship hours for her student affairs and college counseling specialty in a college career counseling center

where she provides counseling services to clients whose ages ranged from 18 to 24 years. Dee has a caseload of five clients of which one has a history of childhood sexual abuse, diagnosis of a disease or disability, and domestic violence. She receives an average of two hours of supervision weekly from a university doctoral supervisor and site supervisor in the format of individual and group sessions. On the survey, Dee reported the death of a loved one when asked about personal trauma experience but did not discuss this during the interview.

Data Analysis

Research Question 4. The first research question for Phase 2 explored how counselors in training explained their levels of vicarious traumatization, as measured by the TABS (Pearlman, 2003) and posttraumatic growth, as measured by PTGI-SF (Cann et al., 2010). The question states: How do counselors in training explain their observed scores on the standardized measurements for vicarious traumatization and posttraumatic growth? After transcribing each interview, the researcher conducted thematic coding for each case noting themes and patterns that emerged from the semi-structured interviews. After completing thematic coding for each case, the researcher completed cross case analyses that included comparing and contrasting themes and evaluating relationships between themes. The data analyses will be presented in two sections. The first section will address vicarious traumatization and the second will address posttraumatic growth.

Vicarious traumatization. The counselors in training shared a variety of responses to explain their observed levels of vicarious traumatization and provided different emotional reactions to their personal scores. In addition, the counselors in

training described personal resources they stated were helpful in managing their responses to working with clients who have a history of trauma (Table 15). There were five common themes that emerged. These included initial reactions of acceptance and surprise, person resource characteristics, similarity to clients, dissimilarity to clients, and coping strategies. The person resource characteristics included education, personal trauma history, indirect experiences of trauma, and supervision. The coping strategies included distraction, exercise, mental health treatment, meditation, mindfulness, relaxation techniques, and spending time with others. Two unique themes that emerged during the within case analysis included having a varied caseload and a greater time before processing session.

Table 15

Explaining Levels of Vicarious Traumatization

Counselor In Training / Theme	H/H			H/L		L/L		L/H
	A	F	I	B	C	G	H	D
Initial Reaction								
Acceptance	X	X	X		X		X	X
Sadness								X
Surprise				X		X		
Person Resource Characteristics								
Education	X				X			
Personal Trauma History	X			X	X	X		
Indirect Experience of Trauma	X	X	X				X	
Supervision	X	X	X	X	X	X	X	X
Similarity to Clients	X			X	X	X	X	
Dissimilarity to Clients			X					X
Coping Strategies								
Distraction	X			X				
Physical Wellness	X					X	X	
Mental Health Treatment				X	X			
Meditation						X		
Mindfulness								X
Prayer			X					
Relaxation							X	
Time with Others	X	X	X	X				
Unique Themes								
Varied Caseload								X
Greater time before supervision				X				

Note. A = Ann; B = Brooke; C = Celia; D = Dee; F = Francine; G = Georgia; H = Holly; I = Ivy. VT: Vicarious Traumatization. PTG: Posttraumatic Growth. H/H = High Vicarious Traumatization, High Posttraumatic Growth; H/L = High Vicarious Traumatization, Low Posttraumatic Growth; L/L = Low Vicarious Traumatization, Low Posttraumatic Growth; L/H = Low Vicarious Traumatization, High Posttraumatic Growth.

Initial Reactions. When asked for their initial reactions to their scores on the TABS (Pearlman, 2003), most of the counselors in training (6 of the 8) expressed acceptance of their scores and two expressed surprise. Ann (high/high) described her reaction as acceptance and confirmation of where she was in her professional development. Ann stated, “I feel that my experience was pretty typical and feel like I am where I should be as an intern.” Celia (high/low) shared she felt her scores “reaffirm[ed] something [she] already knew.” Ivy (high/high) also expressed an acceptance of her score and felt they were representative of her internship experiences. Ivy stated,

I was not necessarily surprised given the internship that I have had because I feel like I probably have had a lot more experiences, like new experiences, than what other peers have had, in terms of dealing with things outside of my comfort zone or what most have experienced growing up.

Brooke (high/low) and Georgia (low/low) expressed surprise about their level of vicarious traumatization. Initially, Brooke, who reported a higher level of vicarious traumatization, expressed surprise and concern that she had “messed up” but later shared she felt her score was a reflection of her experience in internship and in her personal life. Brook stated, “I think [it] is a combination of my experience in internship and I had a lot of stuff going on around the time I started internship that affected me majorly.” Georgia

expressed surprise at her low score and asked if her life experiences and age were a contributing factor.

While Dee (low/low) accepted her lower score of vicarious trauma, she provided a different view and described herself as feeling “sad that people [other counselors in training] experience so much trauma”.

In summary, most of the counselors in training were not surprised and accepted their scores on the TABS (Pearlman, 2003) as a confirmation of their levels of vicarious traumatization. Four of the counselors in training who expressed acceptance also exhibited higher than average levels of vicarious traumatization while the other two exhibited lower than average levels of vicarious traumatization. Dee provided an empathetic response when she expressed sadness that other counselors in training had higher levels of vicarious traumatization.

Person-Resource Characteristics. The counselors in training shared different person resource characteristics they viewed as influencing their levels of vicarious traumatization. Person resource characteristics include current and previous experiences, education, and social and material resources. The person resource characteristics described by the counselors in training encompassed education, indirect experiences of trauma, personal trauma history, and supervision.

Education. Two counselors in training described how education impacted their experience. Specifically, Celia (high/low) and Ann (high/high), who attend different graduate schools, described their education as important in helping prepare them for their practicum and internship experiences.

Celia stated, “I would say that our education sort of prepares us really well for what we are going to experience.” Ann shared a similar statement; “I think our program has prepared me really well.” These counselors in training exhibited higher than average levels of vicarious traumatization.

Indirect Experience of Trauma. Four counselors in training described experiences in which they were exposed to traumatic material either from trainings or from clients. Three of these counselors in training exhibited higher than average levels of vicarious traumatization while one, Holly, exhibited lower than average levels of vicarious traumatization. For counselors in training who are indirectly exposed to trauma, there is an element of learning about the trauma or watching the trauma from the outside.

Francine (high/high) described experiences outside of counseling that impacted her level of vicarious traumatization that included her training and graduate assistant position within Greek life. Francine reported the training she received in her graduate assistant position increased her awareness about “sexual assault statistics and the how increases in alcohol increases the risk of all crimes, especially on a college campus.” In addition, Francine shared that she was more hypervigilant when she went to college bars. Francine stated she is

more aware of the danger involved with going out or just living your day to day life ... [and] I never used to worry about my drink getting drugged or anything like that and now I am little more on edge about those things.

The experience and training as a graduate assistant in Greek life impacted Francine's view of safety and increased her awareness of the potential of violence between college students.

Holly (low/low) described experiences outside of counseling that impacted her low level of vicarious traumatization. Holly shared she has traveled the world and has had many volunteer opportunities. The volunteer activities included working with refugees in Sudan and child patients on a cancer surgical ward at a hospital in Bolivia. Holly shared that because of her life experiences she feels "geared towards work like this. . . . [indicating individuals who have] cancer or some other severe trauma."

Unlike Francine and Holly, Ivy (high/high) shared experiences as a counseling intern that has impacted her higher level of vicarious traumatization. Ivy shared the first time she "had a client who came in from a detention center who was in handcuffs and shackles...[that she] walked away from that session being incredibly impactful to have a kid in hand cuffs sitting in front of you." In addition, Ivy listed experiences of having to call children's services, completing multiple suicidal assessments, including for a seven year old boy, and having to file an involuntary commitment for a 13 year old girl as "difficult on a lot of levels."

Ann (high/high) also shared information related to indirect experiences of family members and friends' accounts of sexual assault as influencing her level of vicarious traumatization. Ann stated,

With me, there was really not a history of sexual or physical abuse per se, but . . . my grandfather did sexually abuse cousins of mine and it was found out later in my family and he was never charged and so it created a lot of trauma for my cousins and I kind of watched it from the outside happen.

The four counselors in training provided information about indirect experiences and exposure to trauma that they viewed as influencing their level of vicarious traumatization. Francine shared her experiences in training that exposed her to information about alcohol and sexual assault on college campuses. Holly shared her life experiences as influencing her lower levels of vicarious traumatization and preparing her for working as a counselor. Ivy shared a different perspective and shared information about internship experiences that had influenced her higher levels of vicarious traumatization. Finally, Ann shared how her knowledge of the sexual molestation of her cousins influenced her level of vicarious traumatization.

Personal Trauma History. Another aspect of personal experience included the personal trauma histories counselors in training shared during their interviews. Fewer individuals discussed their personal trauma histories on the phone interview compared to what they shared on the survey. The personal trauma experiences discussed with the researcher included childhood emotional abuse, parental divorce, familial drug abuse, ending of a relationship, and death of loved ones.

Ann (high/high) saw her own experiences of childhood emotional abuse, knowledge of her grandfather's sexual molestation of cousins, and her exposure to her friends' stories of being raped as influential to her approach to counseling and her level of vicarious traumatization. Ann stated, "With me, there was really not a history of

sexual or physical abuse per se, but my father was emotionally abusive to my mother and to myself and my brother.” Celia (high/low) viewed her experiences of her parent’s divorce, dealing with familial drug abuse, and the recent death of a loved one as influential. Georgia (low/low) shared personal experience of grieving the deaths of three close family members influenced her lower level of vicarious traumatization.

In addition, Brooke (high/low) reported that her experience of getting engaged and ending the engagement within a timeframe of three months impacted her work with clients and her level of vicarious traumatization. Specifically, Brooke shared ended her engagement right before starting her internship because she “found out that everything [she] believed about [her] fiancé was a lie ... and that really affected [her] trust in general.” Brooke reported this challenged her work with couples and contributed to her suspicion about her clients’ honesty.

All but one of the counselors who shared their personal trauma history during the interviews exhibited higher than average levels of vicarious traumatization. The other counselor in training exhibited lower than average levels of vicarious traumatization along with lower than average levels of posttraumatic growth.

Supervision. All eight of the counselors in training reported speaking to their supervisor and seeking supervision to address their uncertainties or process their reactions to clients.

Brooke (high/low) shared that her “...supervisor helped [her] to connect the dots with what [she] was beginning to do with the client and what just happened in [her] life.” Ann (high/high) reported she “...talked with her supervisor [about] how to manage sitting

in [her] own discomfort” during sessions. Celia (high/low) shared her supervisor “encouraged us to make mistakes” as a way to normalize the experience of internship and that there is a lot of support through supervision. Holly (low/low) reported her supervisor also helped normalize her internship experience. Holly stated,

We do training and during that time we learn about different cancers and by the end I was questioning if I have cancer. The next day I met with my supervisor and she shared with me that all of her interns have thought they have cancer when they start here. This helped normalize this with me.

Georgia (low/low) shared that her site supervisor was always available when she asked for additional supervision.

In summary, the counselors in training provided information about the person resources they saw as influencing their levels of vicarious traumatization. Two counselors in training acknowledged education as influencing their vicarious traumatization. Three of the counselors in training discussed their own personal trauma experiences and four described the impact of learning about the trauma experiences of others. In addition, all of the counselors in training shared how supervision was utilized as a social resource to support them in managing their level of vicarious traumatization.

Similarity to Clients. At times, the counselors in training shared that having had similar experiences as their clients impacted their level of vicarious traumatization. Two counselors in training shared how having similar life experiences as their clients influenced their level of vicarious traumatization. Both of these counselors in training

exhibited lower than average levels of posttraumatic growth but levels of vicarious traumatization were higher for one and lower than average for the other.

Celia (high/low) shared that “the students that [she has] similar life experiences with are always going to influence [her] vicarious trauma more.” As an example, Celia reported she worked with a client whose grandparent had died and shared this experience was salient to her because of her own recent personal experience of loss. This was similar to Georgia’s (low/low) expressed comfort level in working with clients who have experienced a loss of a family member. Georgia shared,

I feel that because I have gone through the death of three very close family members that I feel that I sit with their pain and . . . I know they will be okay. I know this because it was okay with me and it was difficult for some time but I survived so I can stay with their pain and their sorrow and their hopelessness and helplessness.

Dissimilarity to Clients. In contrast, two counselors in training shared that their client’s different life experiences impacted their differing levels of vicarious traumatization and higher than average level of posttraumatic growth.

Ivy (high/high) expressed that the exposure to different family experiences, specifically the level of violence among family members, influenced her vicarious traumatization. Ivy shared she had many new experiences at her internship that were “outside of [her] comfort zone or what [she] experienced growing up.” Dee (low/high) also stated that her clients “were very different just from a sense that [she comes] from a different background and always [had her] family’s support.” Both Ivy and Dee

expressed recognition of their status in the social majority, along with their family support, and socioeconomic status differed from their clients.

Coping Skills. The counselors in training described coping skills that assisted them in managing the impact of listening to traumatic stories from their clients and influenced their level of vicarious traumatization. Two of the counselors in training reported accessing mental health treatment. Three counselors in training emphasized physical wellness such as getting enough sleep, eating healthy, and exercise. Two of the counselors in training described distraction strategies that were also negative coping skills (e.g. eating junk food and watching television). Four of the counselors in training described social connections as an important coping strategy.

Celia (high/low) and Brooke (high/low) sought mental health treatment as a way to manage their own personal trauma experiences. Celia shared that her supervisor suggested Celia “seek counseling to be able to sort of separate her own traumas [from the trauma of clients so that Celia could] work with ... students more objectively”. Celia shared this was especially important for when she worked with clients who had with similar issues like divorce or dealing with familial drug abuse. Celia and Brooke exhibited higher than average levels of vicarious traumatization and lower than average levels of posttraumatic growth.

Additional resources described as helpful included physical wellness activities, distraction techniques, and socialization with others. Holly (low/low) expressed the importance of getting enough sleep and Georgia (low/low) described eating healthy as helpful strategies. Ann reported an increased desire to exercise while in internship.

Georgia, Dee (low/high), Holly, and Ivy (high/high) described mindfulness strategies of sitting meditation, breathing, relaxation, and prayer. Others, such as Ann (high/high) and Brooke, mentioned distraction techniques of watching television or eating junk food. In addition, four of the eight counselors in training, all of whom exhibited higher than average levels of vicarious traumatization, described spending time with friends, classmates, or family as helpful.

Varied Caseload. A theme that was unique to Dee, who exhibited low levels of vicarious traumatization and higher than average levels of posttraumatic growth, questioned if having a caseload with clients who have a variety of issues rather than primarily trauma, influenced her low level of vicarious traumatization. Dee stated, “It just makes me wonder is this a result of seeing a wide variety of clients where is not as specific as those working with trauma or is a result of something else.”

Greater Time Before Processing Session. A theme unique to Celia, who had a higher level of vicarious traumatization and lower posttraumatic growth, was the amount of time that passed before she could discuss and process a session with a supervisor or colleague. Celia shared,

in thinking about the VT. The times when I have been able to process something pretty quickly with someone that makes that experience less salient but the times where I have had to go days and sort of sit and think about and not have anyone to talk about it makes that a little worse.

Summary. In summary, the counselors in training shared that the similarity and dissimilarity to clients, personal experiences, personal resources, and coping strategies

influenced their levels of vicarious traumatization. The personal experiences of personal trauma as well as being exposed to the traumas of others were cited as influencing both higher and lower levels of vicarious traumatization. In addition, supervision was described by all of the eight counselors in training as a helpful and supportive resource. The one distinct difference observed between those with a higher level and lower level of vicarious traumatization was the use of mindfulness strategies as a coping skill reported by three counselors in training with a lower level of vicarious traumatization.

Posttraumatic Growth. The counselors in training shared a variety of responses to explain their observed levels of posttraumatic growth. Five common themes emerged including initial reactions of acceptance or surprise, hearing client's stories, personal life experiences, new experiences, and supervision (see Table 16). A unique theme also emerged that was salient for Dee; personal and career values aligned (see Table 16).

Table 16

Explaining Levels of Posttraumatic Growth

Counselor In Training / Theme	H/H			H/L		L/L		L/H
	A	F	I	B	C	G	H	D
Initial Reaction								
Acceptance	X	X	X		X		X	X
Surprise				X		X		
Personal Life								
Experiences		X				X	X	
New Experiences			X		X			
Supervision	X			X	X			
Hearing Client's								
Stories	X	X	X			X		X
Personal & Career								
Values Aligned								X

Note. A = Ann; B = Brooke; C = Celia; D = Dee; F = Francine; G = Georgia; H = Holly; I = Ivy. VT: Vicarious Traumatization. PTG: Posttraumatic Growth. H/H = High Vicarious Traumatization, High Posttraumatic Growth; H/L = High Vicarious Traumatization, Low Posttraumatic Growth; L/L = Low Vicarious Traumatization, Low Posttraumatic Growth; L/H = Low Vicarious Traumatization, High Posttraumatic Growth.

Initial Reaction. When asked for their initial reactions to their scores on the PTGI-SF (Cann et al., 2010) that indicated their level of posttraumatic growth, most of the counselors in training, six out of eight expressed acceptance with their scores. Holly (low/low), who expressed acceptance, reported, “I started out with a certain growth and I have experienced a lot of my own and I have a really strong appreciation for life and empathy and compassion. It makes sense that I am lower than other people.” Georgia (low/low), however, expressed surprise at her below average score and wondered if her life experiences had influenced her growth more so than her interactions with clients

Personal Life Experiences. Three of the counselors in training described life experiences as influencing their posttraumatic growth. Two of these counselors in training exhibited lower than average level of posttraumatic growth and vicarious traumatization where as the third counselor in training exhibited higher than average levels of both posttraumatic growth and vicarious traumatization.

In relation to her surprise at her low posttraumatic growth score, Georgia (low/low) wondered if her life experiences had influenced her growth more so than her interactions with clients. Georgia shared her view that “more experiences maybe gives me a little more resilience . . . I don’t think I am being more sensitive to the issues because I am sitting with my clients.” Holly (low/low) reported, “I started out with a certain growth and I have experienced a lot of my own.” Francine (high/high) also questioned if her growth was more related to her own experiences rather than the exposure to client experiences.

New Experiences. For two counselors in training, a theme of being exposed to new experiences provided them an opportunity for growth. These two counselors exhibited differing levels of posttraumatic growth but both exhibited a higher than average level of vicarious traumatization.

Celia (high/low) stated, “some of the newer experiences like thinking about the preschool where I had not spent much time with children with disabilities” influenced her posttraumatic growth. Ivy also expressed that being exposed to the various experiences of her clients influenced her appreciation for her own family. Ivy (high/high) shared,

I have had a lot of new experiences. I had to make DSS phone calls, and I have had a 7 year old talk about suicidal ideation and I can't tell you the number of clients that are talking about physical altercations with their parents, not liked they spanked me but that they got in a physical fight, 16-15 year olds in fights with their mom or dad. This is so far outside of my experience and I can't imagine being in a space that I would have hit my father or my mother or that they would have hit me. I think that has been very eye opening.

Supervision. Three of the counselors in training mentioned supervision as a supportive resource when asked about posttraumatic growth. The three counselors exhibited higher than average levels of vicarious traumatization. The exhibited level of posttraumatic growth was higher than average for one (Ann) and lower than average for two of the counselors in training (Brooke and Celia).

Celia (high/low) reported that supervision influenced her growth when she received “positive feedback” and she viewed supervision and her internship as an opportunity to see a “client again and redo something.” Ann (high/high) shared, “I think part of that is at my site we do a lot of co-counseling and having my supervisor in with me for a lot of sessions . . . I think really eased me into counseling.” Brooke (high/low) shared that a supervisor in her previous career, “told me never take work home. . . . to protect your family time and to check out.”

Hearing Client's Stories. Five of the counselors in training shared how listening to the stories of their clients impacted their growth and provided perspective.

Dee (low/high) shared that her growth was influenced by,

hearing other people's stories and hearing what people have gone through. Life is hard and everyone goes through their own things and it really gives me an

appreciation for the family I have the opportunities I have been given so it kind of puts it in perspective.

Francine (high/high) shared her perspective of people changed to a more positive view as a result of seeing “clients coming in and having all these positive qualities about them and wanting to change and being at heart really good people.” Georgia (low/low) also reported a shift in her understanding of others and that she now looks beneath the spoken words to the underlying message. Georgia commented that she is “more able to be empathic with family members . . . [and] more appreciative of life.”

Ivy (high/high) expressed greater appreciation for her own family and reported spending more time in prayer and bible study during her semester of internship. Ivy stated, “I have spent more time doing that and process and ultimately being more thankful and greater appreciation for the safety and security of my upbringing.” Ann (high/high) shared her work with clients, “has helped me be a person that is more mindful of what other people go through and so I think it has improved my relationships with other in general in that way.”

Of the five counselors in training who discussed the influence of listening to client’s stories on their level of posttraumatic growth, four exhibited higher than average levels of posttraumatic growth, and three exhibited higher than average levels of vicarious traumatization.

Personal and Career Values Aligned. For Dee (low/low), being in a career that matched her values and strengths was described as influencing her posttraumatic growth. Dee shared her view that choosing a career is a very “personal choice.” Dee stated, “it

feels like my chosen career . . . counseling really fits in line with what my strengths are, what my values are, and what I hope to do, kind of give to others.”

Summary. In summary, the counselors in training shared many common explanations for their levels of high and low posttraumatic growth. The one unique theme that emerged was Dee’s stated belief about the importance of matching career and personal values as influencing her high level of posttraumatic growth. The similar explanations included listening to the stories of others, being exposed to different or new experiences, personal trauma experiences, and supervision. Supervision was not has commonly described as a helpful resource for posttraumatic growth as it was for vicarious traumatization. The only three counselors in training who described supervision as influencing their posttraumatic growth, exhibited higher than average levels of vicarious traumatization. The most common theme where five or six of the counselors in training were in agreement include the initial reaction of acceptance of their level of posttraumatic growth and the impact of hearing client’s stories.

Research Question 5. The final research question examined how counselors in training described the experience the proximal process of counseling clients who have a history of trauma. The research question is stated, “How do counselors in training describe their experiences within the proximal process of providing counseling services to clients who have experienced trauma?” The researcher asked interview questions that sought to understand how the person characteristics of the counselors influenced the proximal process of counseling in addition to exploring how counselors in training prepared or were impacted in the time before, during, and after the counseling sessions

with clients who have a history of trauma. The researcher transcribed each interview verbatim, completed a within case analysis, followed by cross case analyses. The analyses included coding sections of narratives that described elements of the proximal process, person characteristics, context, and time (PPCT) inherent in the PPCT research mode. In addition, themes emerged when counselors in training described their experiences within the proximal process of providing counseling to clients with a history of trauma. The analyses will be presented in the opposite direction of the PPCT research model, with time presented first, followed by context, then person characteristics, and finally proximal process. This is done to highlight how each of the elements is interconnected and interdependent but each contributes to the proximal process, which is at the center of Bronfenbrenner's PPCT research model.

Time. According to CACREP (2009) guidelines, counselors in training are to complete a 600-hour clinical internship, which encompasses 240 hours of direct client contact and 360 indirect hours. Typically, counselors in training complete their internship hours over the course of two semesters. Counselors in training average between 20 to 30 hours a week at their internship site to ensure the necessary hours are completed. Seven of the counselors in training had completed their first internship at the time of the interview, while one, Holly (low/low), had only completed one month of her internship.

The amount of time counselors in training spent at their internship site varied from week day to week day but the total average weekly time spent at the internship site ranged from 20 to 30 hours. For example, Ann (high/high) and Dee (low/high) reported

seeing five to six clients a day and Brooke (high/low) reported a maximum of seven clients for the three days they were at internship. Georgia and Holly, who exhibited low levels of vicarious traumatization and posttraumatic growth, reported seeing two to six clients individually per day plus facilitating two-hour group sessions in the evening. Francine and Ivy, who exhibited high levels of vicarious traumatization and high posttraumatic growth reported completing eight to ten hours of client sessions each week during the 25 to 30 hours they spent at their internship sites across three days. As a school counselor, Celia (high/low) reported a combination of providing individual counseling sessions, case management, and classroom guidance lessons during her 2.5 days at her internship. The counselors in training reported that as full time graduate students they balanced their time between internship and attending class.

When asked about the frequency in which they think about clients outside of the session, the answers varied. Ann and Celia described their drive home as a time during which they reflected on their day and the sessions they had completed with clients. Celia shared sometimes the events of the day and the stories she had heard “kind of hits you like a wave” at the end of the day. Ivy shared that the amount of time,

Depends on the severity. If there was an issue of safety versus the kids who was involuntarily committed – she stayed with me until I received word from the hospital that she was being evaluated. The level of safety concern stays longer. Some of it depends on how long it took me to get to a place where I could do prayer or that kind of stuff. So I would say by that evening I had managed to deal with everything.

Celia shared, “I think the shortest amount of time would have been 2-3 hours, and then the longest time, cumulatively, probably totally about a week. I know that there are still clients that I think about.” Dee also reported still thinking about her clients and wondering how they are doing. Dee stated “there is this element of trying to separate our time and what I think about outside of work and my work with them.”

Brooke shared she arrived 30 minutes to an hour before seeing clients and stated, “I usually have every hour booked even forgets to schedule lunch sometimes”. Holly also shared on her full day at her internship site that she “did not really take lunch.” In contrast, Ann reported her agency closed one hour for lunch and stated she “did not work on the lunch break . . . it was kind of a protection thing for myself.”

In between sessions, Ann and Dee described taking five minutes to refocus and center their selves. Ann shared,

It was hard sometimes to go from session to session and if you had a client who just unloaded really traumatic sad stuff and then you go in to the next session and you have to become a clean slate and you would have 5 minutes in between – that was difficult. In those 5 minutes in between to become a blank slate. I would go to the bathroom between every session, I would take deep breaths and I kind of find a way to process briefly what has happened.

Francine also used paperwork as a transitional task to help her disconnect and process before “moving on to the next client.”

The elements of time that counselors in training discussed extended beyond the hours spent at their internship or the number of clients seen during the day. The counselors in training also discussed the amount of time they would spend thinking about

their client. In addition, the counselors in training described taking breaks in between sessions or doing paperwork as a way to take time for their self in preparation for seeing the next client.

Context. The context examined in this study was limited only to the environment in which the counseling took place; the internship site. The internship sites varied for the counselors in training. Four of the counselors in training worked with clients in an outpatient community mental health agency setting. Others provided services in a high school and preschool, college career center, college counseling center, and a hospital oncology unit.

Beyond the physical description of the setting for their internship, the counselors in training described elements of the environment, which impacted their work with clients. Ann (high/high) shared she picked her outpatient internship site “because it was one of the best.” Ann also reported,

I am also an atheist and I picked the site to because I wanted to challenge myself to work with people because it was faith integrated so I went to the site to challenge myself to broaden that part of my awareness.

Ann stated she did not share her beliefs with her supervisor initially and that withholding this information caused her some anxiety about “being found out.” However, once Ann decided to share her beliefs things shifted for Ann. Ann shared,

I felt more relaxed more confident and felt like there was more of a comradery between myself and the other counselors and the other supervisor. . . . There were a few times where spirituality was integrated into the counseling sessions in a way that I am not sure I approved of but these were rare.

Dee (low/high) also struggled at her internship to balance the goals of the career center with her goals as a counselor. Dee reported the career center, “seems to have a different mentality - we are there when students hit roadblocks or barriers so that there is something specific we are working on to make different or approach in some way and change.” Dee shared it was difficult when she saw other life issues impacting the career choices of her clients because of her view that “it is all connected”. In addition, Dee recognized “how important it is to have counselors in student affairs position”, especially when a student discussing family influences on career choices suddenly disclosed she was sexually assaulted by a family member.

Ivy (high/high) split her internship between the outpatient counseling center and a youth substance abuse residential center. She reported spending time at both locations was necessary to ensure she obtained enough direct clinical hours due to the frequent cancellations at the outpatient counseling center. Ivy also expressed gratitude for the experiences she had at her internship site. Ivy shared, “I feel like my internship has been incredibly challenging for me but I feel like I would rather have these experiences now when I have the amount of support that I have right now.”

In summary, the three counselors in training provided additional information about the context of their internship site. Ann and Dee, shared how their values did not match the values of their internship site. Ann purposefully selected her internship site and was aware of the values mismatch when she started the internship. However, for Dee, the values mismatch emerged during the internship. Both Ann and Dee exhibited higher than average levels of posttraumatic growth. Ivy shared her gratitude for the

challenges she has faced because of her experiences at her internship site. The counselors in training described aspects of the contextual environment of their internship that shaped their internship experience.

Person Characteristics. The person characteristics include demand, force, and resources. Taken together, the person characteristics influence the personal and professional development of the counselor in training. The demand characteristics are those easily observed in a person and included age, race, ethnicity, and sex. The force characteristics include the behavioral disposition and temperaments of the counselors in training that have the ability to initiate, sustain or impede the proximal process. The last person characteristic, resource, includes the counselors in training personal experiences, material resources, and knowledge or skills.

Person Demand. As shared previously, the counselors in training were all females, who were predominantly non-Hispanic and white. The ages of the counselors in training interviewed ranged from 23 to 52 years. When discussing clients and their internship, the counselors in training made no comments about their age or gender as influencing the proximal process of counseling. Three counselors in training expressed their awareness of their own ethnicity, race, and socioeconomic level compared to the ethnicity, race, and socioeconomic levels of their clients. Dee (low/high) shared her awareness that being of the “white majority” made her different from her clients and her clients’ experiences. Ivy (high/high) shared, “We have the same race, white, but he grew up very low SES” when talking about a client. In contrast, Georgia (low/low) reported the client that impacted her the most shared the common trait of being an immigrant.

Dee, Ivy, and Georgia shared this information when asked to describe a client who was most salient to them and made no specific statement about how these differences or similarity impacted their work with clients.

Person Force. Five of the counselors in training shared aspects of their selves and their temperaments that influenced their interactions with clients and the proximal process of counseling. The person force characteristics included over intellectualizing, catastrophizing, anxiety, insecurity, empathy, and depression.

Ann (high/high) shared that in her family of origin she is “the fixer” and often tries to “rush in and fix things”. Ann also shared that she sometimes “intellectualizes too much” which has contributed to her giving too much information during counseling sessions.

Celia (high/low) stated, “I expect the worse” which impacted her anxiety and fear about working with children who have a disability. Celia reported her anxiety and fear subsided after she started her internship but that it was overwhelming initially. Celia’s experience of anxiety and fear had the potential to disrupt the proximal process.

Francine (high/high) described herself as “still feeling relatively insecure in [her] work with clients because the issues are new . . . so it is overwhelming to feel responsible to read up on those.” As a force person characteristic, Francine’s insecurity prompted her to gather additional information, which potentially assisted in sustaining the proximal process of counseling. Dee (low/high) discussed her level of empathy as impacting her work with clients,

For me on strength finder for myself my first strength is empathy. And so while I do feel the strength ... it can also be negative because I feel like I just think about and really wonder how she is doing or how are some of my other students doing like are they okay and there is this element of trying to separate our time and what I think about outside of work and my work with them I think that is a reflection of my empathy.

Dee's observed empathy as measured by the JSE-HP-S (Fields, et.al., 2011) was 118, ($M = 117.71$ ($SD = 10.37$)). Dee's belief in her empathy had the potential to initiate and sustain the proximal process with her clients and potentially contributed to her lower levels of vicarious traumatization.

Brooke (high/low) discussed her feelings of sadness in response to her broken engagement and shared,

I went to talk to my doctor and started a course of antidepressants and things finally broke for me last month. . . . I think I decided that I did not want to be sad anymore. I found a way to have hope again where I didn't have hope for a little while.

Brooke's experiences of sadness potentially impeded the proximal process with clients. For example, Brooke shared her personal experience had "affected my trust in general but even when I would encounter clients I would think, is that true?"

All of these person force characteristics were part of the counselors in training experiences while sitting with clients who have a history of trauma within the proximal process of counseling.

Person Resources. All of the counselors in training were attending graduate school from a CACREP accredited institution. Ann (high/high) and Celia (high/low),

who attended different graduate institutions, each described their education as adequately preparing them for their internship experiences. In addition, all eight counselors in training described supervision as a helpful resource and provided information how supervisors were helpful in the preceding sections.

All eight counselors in training talked about their supervisors. Ivy (high) shared, “A lot of it has been talking it through with my supervisor”. Holly (low/low) described her site supervisor as “amazing” and “always ready and available to talk.” Georgia (low/low) reported she sought extra supervision from her site supervisor. During one session with her site supervisor, Georgia shared,

as I started to cry, I apologized, but my supervisor said “I am so honored to be here with you. I believe being a counselor takes some how sharing the client’s pain and I can see that you are in touch with what is going on with your client.”

Georgia described this experience as very helpful and validating to her. Francine shared her “supervisor walked through some things emotionally” with her to help process Francine’s emotional reactions to clients. Dee (low/high) shared “I was introduced to mindfulness by a doctoral supervisor and I really like that and I have been doing more of that and I think that really helps.” Brooke (high/low) reported, “I talked with my supervisor about it and she gave me some recommendations.”

All but one of the counselors in training reported personal experiences of trauma on the study survey. During the interviews only four of the seven counselors with personal trauma histories described some of those experiences as influencing their level of vicarious traumatization and posttraumatic growth, which as force characteristics has

the potential for sustaining or disrupting the proximal process. In addition, Georgia and Holly shared how their life experiences influenced their ability to sit with clients without experiencing higher levels of vicarious traumatization.

In addition, Ivy, Francine, and Holly reported that having access to other counselors and interns while at their site were an additional resource. Ivy stated she arrived two hours prior to seeing clients during which she completed notes and “talk[ed] to other interns . . . or other counselors.” Francine (high/high) stated “I work with a really small staff at my sight, 3 other counselors at my site . . . I have not felt like just an intern and I have been able to connect with them.”

The person characteristics of demand, force, and resources have the potential to initiate, sustain, and disrupt the proximal process of counseling clients who have a history of trauma. For the counselors in training, the demand characteristics of race, ethnicity, and socioeconomic status were mentioned. When exploring the force characteristics, the counselors in training shared their experiences of fear, the urge to fix things, insecurity, empathy, and depression. In addition, the counselors in training described the personal resources of supervision, collaborating with other colleagues and their experiences as helpful in managing the impact of working with clients who have a history of trauma.

Proximal Process. The counselors in training provided insight into what influenced their work with clients who have a history of trauma. During the within and cross-case analyses four common themes emerged as influencing the reciprocal and ongoing interaction between the counselor in training and client. The codes included presence, connection, emotional reactions, and behaviors utilized in session to helm

manage their emotional reactions or aid clients. Each of these themes will be presented utilizing words from the counselors in training (Table 17).

Table 17

Themes from Within the Proximal Process

Counselor In Training/ Theme	H/H			H/L		L/L		L/H
	A	F	I	B	C	G	H	D
Presence	X	X	X		X		X	
Connection	X	X	X			X		X
Emotions								
Anger	X			X				
Compassion					X		X	
Hope					X	X		X
Sadness	X				X	X		X
Surprise	X	X	X	X				X
Behaviors in Session								
Breathing	X	X						X
Meditation						X		
Relaxation							X	

Note. A = Ann; B = Brooke; C = Celia; D = Dee; F = Francine; G = Georgia; H = Holly; I = Ivy. VT = Vicarious Traumatization. PTG = Posttraumatic Growth. H/H = High Vicarious Traumatization, High Posttraumatic Growth; H/L = High Vicarious Traumatization, Low Posttraumatic Growth; L/L = Low Vicarious Traumatization, Low Posttraumatic Growth; L/H = Low Vicarious Traumatization, High Posttraumatic Growth.

Presence. Five counselors in training articulated their approach toward counseling. Four of the five exhibited higher than average levels of vicarious traumatization with three of the four presented with higher than average levels of

posttraumatic growth. Two counselors in training exhibited lower than average levels of posttraumatic growth with one of the two also presenting with lower than average levels of vicarious traumatization.

The counselors in training described their way of being present and focused when working with clients who have a history of trauma. Ann (high/high), who experienced high levels of both vicarious traumatization and posttraumatic growth, shared,

I know that in a counseling session with a client I have the mindset that they can fall to pieces in front of me somewhat if they need to but I can't do that in front of them I have to be something else for them in the session. Like there's this I feel there is this balance between being empathetic and understanding your clients and caring about them but then also being so immersed in their story that you cannot function as a counselor with them.

Celia (high/low) and Ivy (high/high), both who had high levels of vicarious traumatization, expressed a similar approach with clients. Celia described her awareness of her facial expressions and a desire to not look shocked because she did not want the client to see a look on her face that gave a message to the client "that it is too much or why did you just tell me that or something." Ivy, who experiences high posttraumatic growth, also recognized her own emotional reactions or responses in session and tried "really hard to compartmentalize." Ivy shared,

I need to be present in this space right now and I need to push all of that other stuff that I am feeling . . . I need to put it away because it is not helpful and . . . those reactions are not, they do not have room there, and it is not good for my clients.

Holly (low/low) described a similar approach to working with patients on a hospital oncology ward. Holly stated,

I think the thing that helps the most is being completely genuine but that means I have to go in there with the right mindset. I have to go there completely understanding that I - I never know what I am going to see.

Francine (high/high) described “taking a few deep breaths and re-centering herself” when hearing stories of trauma from clients. For Ann, Celia, Holly, Francine, and Ivy, it was important to create a space where clients could share their story with a counselor who was fully present, empathetic, genuine, and understanding.

Connection. Another aspect that emerged as important was the ability or inability of the counselor in training to connect with their clients. Five of the counselors in training discussed elements of connection. Three of those five also exhibited higher than average levels of vicarious traumatization and posttraumatic growth. The other two counselors in training exhibited lower than average vicarious traumatization. The type of connection was one in which the counselor in training could understand what the client had gone through.

According to Ann (high/high), if the client “had some things in common . . . that [she] connected with . . . [she] could really understand their story or [she] felt like [she] got it more.” There is also an element of connection in Georgia’s (low/low) description of being able to sit with others pain from grief and loss because of her own experience of loss. Georgia shared, “I feel that because I have gone through the death of three very close family members that I feel that I sit with their pain.”

However, for Ann, when there was less in common with her clients, Ann shared, “it was harder” to connect with clients. Francine (high/high) shared she also had difficulty connecting with clients whom she did not share common experiences. Francine stated, there was “a loss of connection and little bit of a loss of understanding on my part” which impacted her comfort and anxiety level because she “did not know how to relate”.

In contrast and despite dissimilarities with clients, Dee (low/high) reported she still “wanted to connect with her (the client) and really meet her where she was and make her feel like I was there with her.”

Georgia offered another perspective. Georgia shared, “if I see hope in the client’s situation, I sit with them in a high level of comfort” and this made working with the client less difficult for her.

Emotional Reactions. To gather more information about what happens in the proximal process inside the counseling session, the researcher asked counselors in training to share what emotions they recalled experiencing while sitting with clients who have a history of trauma and as they discussed the client’s story with the researcher. During their counseling sessions with clients who had a history of trauma, counselors in training reported they experienced multiple emotions including sadness, heaviness, and surprise when they listened to the traumatic stories shared by their clients or bared witness to the client’s expression of pain. Two counselors in training reported feelings of anger. Two others reported feelings of compassion. Four others expressed sadness and three of those four expressed hope. Five of the eight counselors in training expressed feelings of surprise in response to the stories clients shared. In addition, the counselors in

training reported experiencing some of the same feelings during the interview, such as heaviness and sadness.

Brooke (high/low) stated, who exhibited higher than average levels of vicarious traumatization and lower than average levels of posttraumatic growth, stated, “I wanted to cry. When she told me all the things that happened. I wanted to cry. And if I had been watching what she described on a movie, I would have cried.” Dee (low/high) shared, the client “ was in tears, crying her eyes out, and I felt really sad.” Georgia (low/low) shared that “the client who lost custody of her kids was very difficult for me. I had to get a tissue because my eyes were watery.” Celia (high/low) shared that her sadness not only stemmed from the client’s experiences, but also “sadness in the sense that [the client wasn’t] unlike a lot of other students.”

When faced with clients who were tearful and emotional in session, at times the counselors in training expressed feeling surprised. Dee and Brooke expressed surprise when their clients disclosed abuse that had not been discussed or hinted at in previous discussions. Brook shared,

it wasn’t at all what I expected after speaking to her on the phone I don’t think she even expected to open that door. And it was probably the most emotion I have seen expressed in session all the way to crying with heaving and it frightened me for a minute cause I didn’t know really what to do with that except listen and reflect and try to express empathy.

Dee shared that some of the clients “surprised me in what came of our conversation” and then described how a conversation about career choices included a student self-disclosing sexual assault. Dee reported this “kind of took me back a little bit because we were

talking about her family and her eventually talking about maybe what pressures or what other voices she is hearing about her career choices and this [sexual assault] comes up.”

Celia and Holly(low/low) expressed compassion and caring toward their clients. Celia shared, “I guess you sort of get attached to your students and I guess sort of you start to care for them in a way that you care for other people that are close to you.” Holly stated, “I feel a lot of compassion.”

In times after the session, the counselors in training expressed they had feelings of anger, frustration, and sadness. Ann shared she “felt very deeply angry” for the client and the client’s situation. Dee reported, “I was kind of frustrated that that [sexual assault] had happened and that she [the client] has to go through that and it just didn’t seem fair.”

Many of them also shared that the experience of talking to the researcher about these clients during the interview impacted them and stirred emotions. Dee stated, “even just as I’m thinking about it I feel like my body slumped. It is so heavy.” Ann also used the word heavy in her statement: “I am getting a little bit tearful. I guess . . . my chest feels a little heavy.” In addition, Ann shared she had to terminate with this client and reported,

I still feel some sadness honestly. . . . I know he [the client] is going to see a counselor that I was working with and the counselor is fantastic and he is connected to her too. But I kind of had this worry about what if I am another loss for him.

Brooke expressed “feeling a little emotional”. Celia shared that discussing the client, “still pulls at my heartstrings a little bit.” Holly expressed a similar emotion when

discussing the client. Holly stated, “it is heartwarming.” The counselors in training also expressed hope. Celia shared,

I guess it is sort of overwhelming sometimes, the struggles that children and adolescents have to face that you as an adult can see and they don’t see yet. But I always feel like that it is sort of like full of hope for all of these people.

Dee shared, “hopefully she [the client] will follow up with me if she hits a barrier.”

Georgia expressed, “it is always good to talk about her [the client] because I have this hope that by talking about her some piece of the puzzle can come together.”

The counselors in training shared a variety of emotional reactions when discussing their clients and two patterns emerged. The counselors in training who exhibited higher than average levels of vicarious traumatization all expressed surprise.

Behaviors in Session. In addition to emotional reactions, the counselors in training shared some of the things they did during the session to either soothe the client or manage the reactions they had while listening to the client’s story or the observing the client’s expression of emotions. The common behaviors included breathing, listening and attending with empathy, use of reflections, meditation, and relaxation techniques. Three counselors in training mentioned breathing. One counselor expressed using attending, while another described using reflections in order to listen and empathically attending to their client. Another counselor in training taught meditation while another counselor in training taught relaxation techniques to clients.

Ann (high/high) reported when clients expressed emotion, “in those moments [she] would try to reflect feelings and give them [the client] some privacy with my

nonverbal – not staring at them directly, if they became tearful offering them the Kleenex.” Brooke (high/low) also reported she listened and attended to the client with “empathy.” Francine (high/high) stated she would take deep breaths to help “re-center” and refocus herself when hearing stories of trauma from clients.

In addition, the counselors in training reported facilitating different activities with clients during sessions. Ann stated she facilitated deep breathing with two different clients who became “panicked in session”. Holly (low/low) reported she facilitated relaxation exercises with her clients. Holly shared, “I have used those [relaxation techniques] a lot in my job.” Georgia (low/low) reported she taught meditation techniques to her clients and would sometimes “sit” with them in meditation.

In summary, the counselors in training described common themes of being present in session, shared their ability and inability to connect with clients, expressed many emotions, and discussed strategies they used during the sessions manage their reactions to the stories of trauma shared by their clients. In sharing this information, the counselors in training provided a glimpse of what it was like for them as they entered into the proximal process of counseling and empathically engaged with clients who have a history of trauma

Summary. In evaluating how counselors in training explain their experiences within the proximal process of counseling clients who have experienced trauma. The counselors in training shared their perceptions of what it was like to listen to clients share their stories of trauma and observe clients expressions of emotion. The counselors in training also shared their emotional reactions as well as coping strategies utilized during

session to manage their reactions. In addition, the counselors in training discussed different coping strategies. Supervision was described as a resource and four counselors in training shared information about their own personal trauma experiences. In addition to the person characteristics, the counselors in training described elements of the context and time that shaped their internship. All of this information, when placed together, have provided a glimpse of how the counselors in training experience the proximal process of counseling clients who have a history of trauma.

Summary

In this chapter, the researcher has provided the results of the data analyses computed in Phase 1, the quantitative portion of the study, and the analyses of the qualitative data obtained during semi-structured interviews in Phase 2. The data from Phase 1 highlighted the results from the survey, while Phase 2 data highlighted the information shared with the researcher by selected counselors in training. The information from Phase 2 also provided a thematic evaluation of how counselors in training experienced vicarious traumatization and posttraumatic growth. In the following chapter, the researcher will discuss the results, provide implications for practice and future research, and address limitations of the current study.

CHAPTER V

DISCUSSION

Introduction

The purpose of this study was to examine vicarious traumatization and posttraumatic growth, explore how each construct was influenced by personal characteristics of the counselor in training, and give voice to counselors in training about their initial experiences within the proximal process as they engaged with clients who had been traumatized. In this section, the researcher will discuss the major findings and implications of this study based on the results presented in Chapter IV. First, the findings from the data analyses utilized to answer the research questions will be discussed and linked to relevant research literature. The researcher will evaluate conflicting explanations and discuss any unexpected findings. Next, the researcher will present theoretical and research implications of the study. The implications will include information for counselor educators, supervisors, and counselors. Finally, the researcher will address limitations of the current study and provide suggestions for future research.

Discussion of the Results

Counselors in training in the current study exhibited an average level of vicarious traumatization. An average level of vicarious traumatization indicates that counselors in training were exposed to client trauma narratives that challenged their own beliefs about their self as competent, others as trustworthy, and the world as a safe place. This is most

evident in counselors in training with a higher than the current study's mean of vicarious traumatization as noted during the qualitative phase of the interview. Francine, who exhibited the highest level of vicarious traumatization in this study, reported she sees the world as less safe than when she previously began her internship and expressed feelings of insecurity in working with new or unfamiliar client issues.

It was hypothesized that counselor in training would exhibit some level of vicarious traumatization. According to McCann and Pearlman (1990b), vicarious traumatization is considered "a normal reaction to the stressful and sometimes traumatizing work" with clients who have a history of trauma. Canfield (2008) also reported a common theme that vicarious traumatization is a normal reaction to doing trauma work that emerged during her review of qualitative studies on vicarious traumatization and burnout. This is similar to the responses provided by counselors in training during the qualitative phase of this study who expressed acceptance of their higher than the current study's mean scores of vicarious traumatization.

What was unexpected was that the level of vicarious traumatization experienced by the counselors in training in this study would be similar to levels observed in more experienced professionals. The professionals in the study by Williams, Helm, and Clemens (2012) reported an average of working at least ten years in the field of community mental health. Williams and colleagues (2012) reported the community mental health professionals in their study exhibited an average score of 175.02 ($SD = 36.97$) on the TABS (Pearlman, 2003) with total raw scores ranging from 113 to 327. On the same measure, counselors in training in this study exhibited an average score of

171.51 ($SD = 35.36$) and total raw scores ranged from 103 to 256. So while vicarious traumatization scores in the current study of trainees did not reach as high of levels as the professional, experienced counselors, the average experience of vicarious traumatization was similar. Another similarity between the current counselors in training and professional counselors in the study by Williams and colleagues (2012) was the experience of having at least half of one's caseload reporting a history of trauma. Although CSDT, indicates that increased and cumulative exposure to client trauma would contribute to higher levels of vicarious traumatization, this was not found in the results of the current study and the study by Williams and colleagues (2012).

While a significant finding was expected, counselors in training exposed with a 49% or greater caseload of clients with a history of trauma versus trainees with less than half of their clients having experienced a history of trauma were not significantly different in their vicarious traumatization scores. This may be due to an unexpected small effect size (Cohen's $d = .134$) which resulted in a low power (.121); therefore the non-significant finding may have been influenced by a small sample size and small effect size, which increased the potential for Type II error. This indicates the potential that the exposure to client trauma may indeed influence higher levels of vicarious traumatization but due to small sample size and effect size, there was not adequate power to reject the hypotheses that increased client exposure influences vicarious traumatization. Unlike the current study and the study by Williams and colleagues (2012), Schauben and Frazier (1995) reported experienced psychologists with a caseload where 45% of clients had a history of trauma significantly predicted higher levels of vicarious traumatization.

However, despite the amount of exposure to client trauma, the counselors in training who participated in this study demonstrated a level of vicarious traumatization at the same rate as professionals who had been providing counseling services to clients for at least 10 years.

When considering what influenced the higher levels of vicarious traumatization, additional information can be gleaned from the semi-structured interviews. There is some indication that working with adolescents with a history of trauma contributed to higher levels of vicarious traumatization than working with adults with a trauma history. For example, Ivy, who had a higher than average level of vicarious traumatization, reported a caseload of which 60% had a history of trauma. In contrast to Ivy, Georgia, who had a lower than average level of vicarious traumatization, reported a caseload with 80% of clients with a history of trauma. The one notable difference between Ivy and Georgia is that Ivy worked with adolescents and Georgia worked primarily with adults. While generalizations can not be made from the small number of interviews, or from these two individuals, the type of client may be important to look into when exploring vicarious trauma of counselors. It should be noted, however, that Brady, Poelstra, Guy, and Brokaw (1999) reported that psychotherapists who worked with children as opposed to adults with a history of trauma did not have significantly higher levels of vicarious traumatization; however, this may have been due to the years of experience they had been exposed to clients with trauma. What needs to be further explored however is if the effect of the type of clients would be different for counselors in training than for experienced mental health professionals.

While overall caseload of clients with trauma did not appear to impact levels of vicarious traumatization, one theme that emerged in the qualitative interviews was that of mindfulness as a strategy to cope with clients expressing a history of trauma. This theme seemed to differentiate counselors in training with lower than average levels of vicarious traumatization compared to those with higher vicarious traumatization. In the results of an evaluation of five qualitative studies on mindfulness with graduate counseling students, Christopher and Maris (2010) reported mindfulness strategies positively influenced personal wellbeing and the therapeutic relationship. In addition, Harrison and Westwood (2009) reported mindfulness emerged as a common theme in a qualitative inquiry about vicarious traumatization with experienced mental health professionals. At this time, researchers have not yet quantitatively evaluated how mindfulness might influence the level of vicarious traumatization and assist in managing the impact of listening to client trauma narratives.

Supervision has been described in the research literature as influential to help ease the impact of listening to client's stories about trauma and baring witness to the client's emotion. Harrison and Westwood (2009) described supervision as an ethical component in minimizing impairment to counselors and minimizing the risk of harm to clients. In the current study, supervision was described by all eight counselors in training in the qualitative phase as a helpful resource. In addition, counselors in training receiving at least 2.5 hours or more of supervision in a week had significantly lower levels vicarious traumatization. This finding had a large effect (Cohen's $d = .715$). Supervision was a supportive resource for the counselors in this study to help manage the impact of working

with clients who have a history of trauma. Therefore, having at least 2.5 hours of supervision each week, as required by CACREP (2009) standards, assists in decreasing the level of vicarious traumatization for counselors in training. This finding is supported by a theme that emerged in a study by Sommer and Cox (2005) which expressed a need that vicarious traumatization be addressed in supervision as a way to normalize the experiences of dealing with traumatic narratives from clients. This is similar to how supervision, as conceptualized by Etherington (2000), is described as a safe harbor in which counselors can express and explore their feelings about their clients and their work.

Empathy has been described by Carl Rogers (1957) as the most important core condition when working with clients. The level of empathy exhibited in this study by most of the counselors in training centered around the mean ($M = 117.71$, $SD = 10.37$; range 80 - 137), indicating that most of the counselors in training exhibited moderate to high levels of empathy. This is similar to what other researchers have found with experienced mental health and other health professionals (Fields et.al., 2011; Harrison & Westwood, 2009; Hojat et al., 2002; Linley & Joseph, 2007). When examining the influence of empathy on vicarious traumatization in the current study, empathy was found to significantly influence the level of vicarious traumatization. Specifically, empathy was the only significant predictor of vicarious traumatization with the hierarchical regression model explaining 33% when supervision was included. According to the commonality analysis, empathy uniquely contributed to 25% of the variance in the levels of vicarious traumatization observed for the counselors in training

in this study. In addition, the counselors in training described empathy as an important component for their work with clients during the interviews. Dee, who exhibited an average level of empathy and lower than average vicarious traumatization with higher than average posttraumatic growth, shared that she saw empathy as the biggest strength that assisted her in working with clients.

Harrison and Westwood (2009) described empathy as a way of being highly present and sensitively attuned when working with clients. Presence was a common theme that emerged from the qualitative phase of this study. The five counselors in training who described aspects of presence shared how centering their self and focusing on the client allowed them to be present with and fully available to the client. This provides a glimpse of how counselors in training are present and how they empathically engage with clients. Given the similar levels of empathy among the current participants, and in experienced professionals, this may be what has opened them up to experience similar levels of vicarious trauma. In addition, the combination of empathy and hours of supervision was found to account for 33% of the variance in vicarious traumatization. This finding had a moderate effect size ($f^2 = .497$), which was in line with study hypotheses. Other researchers have conceptualized the importance of empathy in relation to vicarious traumatization (Pearlman & Saakvitne, 1995; Sexton, 1999). In addition empathy emerged as an important protective factor against vicarious traumatization in a qualitative study by Harrison and Westwood (2007). The current study was the first to go beyond conceptualization by quantitatively examining empathy in relation to vicarious traumatization, suggesting additional research is warranted.

Posttraumatic growth, the growth that people experience as a result of experiencing a crisis, also warrants additional research. In the current study, counselors in training exhibited a mean score of 28 ($SD = 9.04$; range 0 - 44) on the Posttraumatic Growth Inventory-Short Form (PTGI-SF; Cann et al., 2010). The mean score indicates that counselors in training experienced a moderate degree of degree of growth in relating to others, new possibilities, personal strength, spiritual change, and appreciation for life since beginning to see clients. Brockhouse and colleagues (2011) and Linley and Joseph (2007) also reported a moderate level of posttraumatic growth for therapists in their studies who had 13 to 15 years of experience. These researchers utilized the full version of the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) on which the comparable PTGI-SF (Cann et al., 2010) was based. Despite the counselors in training in this study having less experience, the trainees exhibited similar levels of posttraumatic growth.

Additional information can be gleamed from interviews conducted during the qualitative phase of the study. During interviews, counselors in training described having a greater appreciation for their relationships with others and their own lives as a result of hearing the trauma narratives of their clients. Four of these trainees also exhibited higher than average levels of posttraumatic growth. Participants in a qualitative study by Goldenberg (2002) also expressed a greater appreciation for life and relationships with others as a result of listening to stories from Holocaust survivors. In contrast, three of the counselors in training, two of whom at lower than average levels of posttraumatic growth and one had a higher than average level of growth, described their growth as resulting

from experiences outside of working with clients. It may be necessary in future research to try and tease apart the growth that has occurred outside of working with clients versus the growth that may occur due to work with clients. Thus, it seems important to explore the level of posttraumatic growth across time.

Empathy has also been described and evaluated as an influential variable of posttraumatic growth. Brockhouse and colleagues (2011) reported a positive correlation between empathy and posttraumatic growth. An earlier study by Linley and Joseph (2007) reported empathy significantly predicted higher scores on the PTGI (Tedeschi & Calhoun, 1996). In the current study, empathy was found to contribute only 0.2% of the variance in posttraumatic growth and the regression model was not significant. However, a post hoc analysis computed power to be .058; therefore the non-significant finding may have been the result of a Type II error. This indicates the potential that empathy may influence higher levels of posttraumatic growth but due to small sample size and very small effect size ($f^2 = .002$), there was not adequate power to reject the hypotheses that increased empathy influences posttraumatic growth. It is likely that a larger sample size (e.g. 55) that satisfies a priori power analysis requirements would evaluate how empathy influences posttraumatic growth.

Supervision, like empathy, was not found to significantly influence posttraumatic growth in this study. More specifically no significant differences in levels of posttraumatic growth were found between counselors in training that had 2.5 hours or more of supervision per week versus those who had less supervision per week. Similar to exploring the relation between empathy and posttraumatic growth, this may have been

due to low power found in a post hoc analysis (.289); therefore the non-significant finding may have been due to a Type II error. The lack of power does not allow for a conclusion to be drawn regarding the influence of supervision and posttraumatic growth for counselors in training; however, information can be gleaned from the qualitative interviews in the current study. During the qualitative phase of this study, three of the eight counselors in training described supervision as a facilitative factor of their posttraumatic growth. The trainees shared that their supervisors provided them with positive feedback, encouraged them to take risks and make mistakes, were readily available for consultation, and advised them not to take work home. While the relationship between supervision and posttraumatic growth was unable to be fully answered in the current study, Brockhouse and colleagues (2011) and Linley and Joseph (2007) reported therapists receiving supervision exhibited higher levels of posttraumatic growth when compared to those not receiving supervision. These researchers did not set a threshold for the amount of supervision received, likely due to the lack of standards requiring supervision after independent licensure. However, researchers have advocated that counselors should receive supervision regardless of the level of license or years of experience (Bell, Kulkarni, & Dalton, 2003; Brockhouse et al., 2011; Harrison & Westwood, 2009; Linley & Joseph, 2007; Pearlman & Mac Ian, 1995; Sommer, 2008).

In the current study, counselors in training were asked to respond yes or no to having a personal history of trauma. Of those who participated, 68.6% reported at least one personal trauma experience. However, having a personal trauma history was not found to significantly influence vicarious traumatization nor posttraumatic growth. In

evaluating vicarious traumatization, an a priori power analysis was conducted expecting a moderate effect size based on previous findings; however, a very small effect size (Cohen's $d = .071$) was observed when comparing levels of vicarious traumatization between counselors in training who had a personal trauma history compared to trainees who did not have a personal trauma history. A post hoc power analysis computed power to be .070; therefore the non-significant finding may have been influenced by a small sample size and small effect size, which increased the potential for Type II error. This indicates the potential that personal trauma history may influence levels of vicarious traumatization but due to small sample size and very small effect size, there was not adequate power to reject the hypotheses that having a personal trauma history does not influence vicarious traumatization.

Additional information can be gleaned from the interviews conducted during the qualitative phase of the study. Four of the eight counselors in training who participated in the qualitative phase described their personal trauma experiences as impacting their level of vicarious traumatization. Three of the four exhibited higher than average levels of vicarious traumatization while one exhibited a level that was lower than the average experience of vicarious traumatization observed for this study. In addition, the personal trauma experiences of two of the counselors in training, Brooke and Celia, occurred right before the start of their internship experiences. The links the counselors in training made during the interviews between their own personal trauma history and their levels of vicarious traumatization appears to contradict the quantitative results; however, the latter could be due to Type II error. Nevertheless, the mixed results are consistent with findings

reported by other researchers. Trippany, Wilcoxon, and Satcher (2003) described personal trauma history as a significant predictor of vicarious traumatization for experienced therapists working with clients who reported a history of sexual trauma. Young (1999) also described personal trauma history as significantly correlated to vicarious traumatization among psychologist's working with children who had a history of abuse. In contrast, the studies by Schauben and Frazier (1995) and Adams, Matto, and Harrington (2001) reported no significant relationship between personal trauma history and vicarious traumatization.

When evaluating personal trauma history and posttraumatic growth, a priori power analysis was conducted expecting a moderate effect size based on previous findings. A moderate effect size (Cohen's $d = .459$) was observed when comparing levels of posttraumatic growth between counselors in training who had a personal trauma history and trainees who did not have a personal trauma history and post hoc power analysis computed power to be .751. Although a non-significant result, there is adequate power to describe personal trauma as not influencing levels of posttraumatic growth in the current study. This is similar to the study by Brockhouse and colleagues (2011) who reported no differences in posttraumatic growth between experienced therapists with and without a personal trauma history. In contrast, the studies by Lambert and Lawson (2013) and Linley and Joseph (2007) reported as a result of therapy work counselors with a personal trauma history exhibited higher levels of posttraumatic growth than those without a personal trauma history.

However, information shared by counselors in training during the qualitative phase of this study provides implications that personal trauma history did not impact the posttraumatic growth as a result of working with clients. There were two distinct patterns shared by the counselors in training that exhibited lower than average levels of posttraumatic growth. The first pattern was the insight shared by two trainees that their past experiences, including personal trauma, impacting their growth prior to starting graduate school and was not as a result of working with clients. The second pattern observed was a similarity between the trainees' personal trauma experience and that of their clients. Two counselors in training shared that their recent personal trauma experiences that were similar to their client's trauma experiences, impacted not only their lower than average level of posttraumatic growth but also their higher than average level of vicarious traumatization. In the study by Lambert and Lawson (2013) common trauma experiences between counselor and client were reported to significantly influence higher levels of posttraumatic growth.

As with vicarious traumatization, the results reported by previous researchers and within the current study are mixed and do not provide conclusive information on how having a personal trauma history influences levels of posttraumatic growth. It remains unclear how the timing of a personal trauma experience in addition to that personal trauma being similar to one's clients impacts the posttraumatic growth and vicarious traumatization. Although there is some indication, based on the qualitative inquiry in this study, that when counselors in training experience a recent trauma and that trauma is similar to clients experiences, that higher than average levels of vicarious traumatization

may be exhibited. Another reason that could have influenced the higher level of vicarious traumatization is that seeking personal therapy has been observed to influence and increase levels of vicarious traumatization as noted by Pearlman and Mac Ian (1995) and as evident in the information shared by two of the trainees from the qualitative phase of this study. The relation between posttraumatic growth and counselors who seek personal therapy has not been explored. Other reasons that contribute to the inconclusive results of how personal trauma experiences influence vicarious traumatization and posttraumatic growth include the social stigma of addressing one's own personal trauma and one's ability to view their self as being traumatized by their work with clients. In addition, it is possible that different types of personal trauma experiences influence vicarious traumatization and posttraumatic growth differently. Researchers have compared how working with clients with different personal trauma experiences impact the counselor (Cunningham, 2003; Kadambi & Truscott, 2004), but have not examined how personal trauma experiences of the counselor impact the counselor's own level of vicarious traumatization and posttraumatic growth. The mixed results of this study and previous studies indicate a need for additional research.

The Constructivist Self-Development Theory (CSDT) from McCann and Pearlman (1990) along with elements of the Proximal Process, Person, Context, Time (PPCT) research model from Bronfenbrenner's bioecological theory of human development have been utilized as theoretical frameworks for this study. Both of these theories emphasize cumulative exposure, adaptation, and address various aspects of the counselor in training that are impacted when working with clients who have a history of

trauma. In evaluating the theoretical framework for this study, there were elements found to be supportive and unsupportive of using the CSDT and PPCT to conceptualize of vicarious traumatization and posttraumatic growth.

The CSDT includes five psychological needs as internally motivating behavior described to supports one's need for safety, esteem, trust, control, and intimacy (McCann & Pearlman, 1990a, 1990b; Saakvitne & Pearlman, 1996). There was contributing information from interviews that described aspects of disruption to psychological needs by those who exhibited higher than average levels of vicarious traumatization. Specifically, the need for safety by Francine, the need for trust and intimacy by Brooke, and the need to feel competent and have esteem about their abilities by Francine. In contrast, Dee, who exhibited a lower than average level of vicarious traumatization and a higher than average level of posttraumatic growth, demonstrated an undisrupted need of control in her recognition about the disparity of others situations and her inability to control the traumatic experiences of others. Holly also exhibited an undisrupted need of control when she shared her awareness about never knowing what she was going to see when she walked into a patient's room on the oncology unit at her internship. In addition, five of the eight counselors in training interviewed, described how hearing the stories of others increased their appreciation for their relationships, which highlights the need of intimacy. Pearlman and Mac Ian (1995) also reported significant disruption to the psychological needs and cognitive schema of trust, intimacy, and esteem for trauma therapists with two or less years of experience. During phase two of the current study, counselors in training shared information related to the disruption of trust and esteem as

well as enhanced levels of intimacy. Tedeschi (1999) described safety as also including the recognition of one's vulnerability, which may lead to an increased utilization of social supports. This is evident in the qualitative phase of this study in which four counselors in training, who exhibited higher than average levels of vicarious traumatization, described spending time with others as a way to cope with the impact of working with clients who have a history of trauma. In the current study, CSDT assisted in understanding how the psychological needs of trust, safety, esteem, control and, intimacy were impacted when working with clients who have a history of trauma and how these contributed to levels of vicarious traumatization and posttraumatic growth.

The addition of the PPCT research model provided a framework to explore how counselors in training described their initial experiences within the proximal process of counseling clients who have a history of trauma. The counselors in training shared their view that being present and connecting with clients shaped the proximal process of counseling and the therapeutic relationship. In addition, the counselors in training described how they were emotionally impacted during counseling sessions when clients shared their trauma narratives and during the semi-structured interviews. The interviews helped paint a picture of the proximal process of counseling where counselors in training interacted with clients who have a history of trauma, observed the emotional responses of clients, and consulted with supervisors. Many of the counselors in training spent 20 to 30 hours a week at their internship of which eight to 10 hours were spent directly with clients. When evaluating the entire PPCT research model against the experiences of the counselors in training, each trainee provided information that contained unique instances

in addition to sharing common themes of presence, connection, emotion, and behaviors in session. According to Bronfenbrenner and Morris (2006), the power of the proximal process varies based on the characteristics of the individual (trainee), the environment (internship), and developmental outcome (vicarious traumatization and posttraumatic growth).

When evaluating the results from the quantitative phase of the current study, some of the results supported the theoretical conceptual framework, while others did not. Specifically, empathy was conceptualized as a contributing factor for counselors in training to be at risk for developing vicarious traumatized and have the opportunity to develop posttraumatic growth. In the current study, empathy was found as contributing to vicarious traumatization but not to posttraumatic growth. Supervision, as a person resource characteristic, was found to assist in decreasing levels of vicarious traumatization when counselors in training received at least 2.5 hours weekly of supervision. However, supervision was not found to influence levels of posttraumatic growth. Personal trauma history, another person resource characteristic, was also not found to significantly influence vicarious traumatization and posttraumatic growth. Within CSDT, the cumulative experiences and exposure to client trauma has been conceptualized to increase levels of vicarious traumatization and posttraumatic growth. However, in this study exposure to client trauma did not significantly increase posttraumatic growth or vicarious traumatization. Therefore, additional research is needed to further evaluate the application of CSDT in understanding vicarious traumatization and posttraumatic growth.

The theoretical framework of CSDT in conjunction with the PPCT research model provided a glimpse of how counselors in training are impacted by working with clients who have a history of trauma. CSDT highlighted how psychological needs of the counselors in training were impacted when working with trauma, while PPCT provided additional information as to how the counseling process was impacted. Specifically, PPCT allowed for a deeper evaluation of how the counselors in training experienced the disruption of psychological needs and how this disruption impacted their work with clients. While it is clear that counselors in training exhibit a level of vicarious traumatization and posttraumatic growth that is comparable to professionals who have worked in the field for 10 to 15 years, there are inconclusive results as to what significantly contributes to the development of these constructs. In the current study, the combination of empathy and hours of supervision were reported to significantly influence levels of vicarious traumatization. The other variables of exposure to client trauma and personal trauma history were found to not significantly influence vicarious traumatization. This claim is made cautiously due to the observed small effect sizes and small sample size, which may inherently contribute to the possibility of Type II error.

Also in the current study, empathy, supervision hours, exposure to client trauma, and personal trauma history were reported to not significantly influence posttraumatic growth. There are indications, based on the current study and reviewed research literature, that the development of vicarious traumatization is influenced more by experiences outside the counselor in training (e.g. supervision, caseload, exposure to client trauma) while posttraumatic growth is influenced by the internal experiences of the

counselor in training (e.g. personal trauma experiences). It is possible that the counselor's personal trauma history is compounded by the exposure to the client's trauma history. Future studies could evaluate the potential for an interaction or moderating effect of personal trauma and client trauma on vicarious traumatization and posttraumatic growth. There is also an element of revisiting the trauma material and the trainee or counselor's meaning making process of understanding trauma that may influence the development of these constructs. Researchers have evaluated rumination in the forms of deliberate and intrusive as influencing posttraumatic growth (Calhoun, Cann, Tedeschi, & McMillan, 2000; Cann et al., 2011). Inherent in the reported results are theoretical implications, recommendations for counselor educators and supervisors, and implications for future research that will be discussed in subsequent sections.

Implications

Implications for Theory

In considering theoretical implications it is important to address the limitations of only evaluating vicarious traumatization and posttraumatic growth from the framework of only the Constructivist Self-Development Theory (CSDT). The current study supported CSDT as a framework for understanding the impact of vicarious traumatization on the psychological needs and cognitive schemas. During phase two of the study, counselors in training described disruption to their psychological needs of trust, intimacy, safety, esteem and, control. However, the theoretical perspective of how personal trauma history and exposure to client trauma were conceptualized by CSDT to influence vicarious traumatization and posttraumatic growth were not supported by the results of this study.

The additional lens of the proximal process, person, context, and time (PPCT) research model as proposed by Bronfenbrenner's bioecological theory of human development provides a more in-depth evaluation of vicarious traumatization and posttraumatic growth. The PPCT research model provides a framework for evaluating the interplay of interactions within the proximal process of counseling, the person characteristics of the counselor in training, the contextual environments in which the counselor in training interacts, and elements of time that influence the reciprocal interactions with clients. Further, the PPCT research model in conjunction with CSDT provides more depth to results that have been reported to demonstrate the utility of the CSDT. McCann and Pearlman (1990) described CSDT as viewing the counselor's unique responses to client trauma narratives as shaped by characteristics of the situation and the counselor's unique psychological needs and cognitive schema. This is similar to Bronfenbrenner's view that the interplay of person characteristics in conjunction with context places the person as both a producer and product of development within their environment (Bronfenbrenner & Morris, 2006). Further, Bronfenbrenner stated that the combinations of these characteristics create distinct and unique patterns in the person, which account for differences in a person's character as distinguished in the direction and power of proximal processes toward competency (Bronfenbrenner & Morris, 2006). When combined, these theories provide a way to further explore and understand some of the conflicting findings that the current study and other researchers have found. For example, the understanding of how personal trauma history impacts vicarious traumatization and posttraumatic growth could be enhanced by also looking at when the

personal trauma experience occurred and similarities between the trauma experiences of client and trainee. The theoretical frameworks of CSDT and the PPCT research model provides an in depth perspective to further evaluate the conflicting results in relation to these constructs.

While this study did not set out to test the utility of these theories, there is indication that the utilization of CSDT in conjunction with PPCT provides a more in-depth evaluation of vicarious traumatization and posttraumatic growth. PPCT allows for a clearer understanding of how disrupted psychological needs of the counselors in training impacted the proximal process of counseling. It is suggested future research that examines either or both vicarious traumatization and posttraumatic growth evaluate the utility of Bronfenbrenner's bioecological theory of human development and examine the significance of the PPCT research model, along with continuing to utilize the CSDT. CSDT provides the original framework for understanding how working with clients who have a history of trauma impacts and potentially disrupts the trainee's view of their self as competent, others as trustworthy, and the world as a safe place. The additional lens of PPCT assists in understanding how these psychological needs when challenged or disrupted impacts how counselors in training relate to their clients, approach counseling sessions, and impacts the proximal process of counseling. In combining CSDT and Bronfenbrenner's bioecological theory of human development and PPCT research model, a more complete picture of how professional helpers are impacted when exposed to the traumatic narratives of clients will be illuminated. This is especially important, as the utilization of CSDT has not yielded a more unified approach in evaluating the impact of

working with clients who have trauma. Whether the impact is vicarious traumatization or posttraumatic growth, it is clear a more unified and comprehensive way to examine the effects of working with trauma is warranted and the information in this study has demonstrated the utility of combining CSDT with the PPCT research model as an integrative theoretical framework.

Implications for Practice

The most important element and implication for counselors in training, counselor educators, and supervisors is awareness that counselors in training experience vicarious traumatization and posttraumatic growth at a level similar to independently licensed professional counselors. This awareness has implications for counselors in training, counselor educators, and supervisors. The qualitative results obtained during this study provide additional support. Three of the counselors in training interviewed reported they implemented personal mindfulness techniques, such as deep breathing, meditation, or relaxation to cope with the impact of working with clients who have a trauma history. These three counselors in training were also observed to have lower levels of vicarious traumatization and one of them also exhibited higher than average levels of posttraumatic growth. As noted in previous research, wellness is an important factor for sustaining wellbeing, which impacts the quality of services provided (Lawson, 2007). Other researchers have reported that participating in wellness activities assists in decreasing vulnerability to vicarious traumatization (Pearlman & Saakvitne, 1995; Williams et al., 2012). This suggests that counselors in training could benefit from the implementation of mindfulness activities as part of their internship training. In addition, the training of

mindfulness would support the counselors in training ability to monitor their own effectiveness and signs of impairment, which is in line with ethical codes of the American Counseling Association (ACA, 2014, C.2.d. & C.2.g.).

Counselor educators and supervisors are also under ethical obligation to evaluate the counselor in training (ACA, 2014, F.9.a., F.8.d., F.1.a., & F.6.d.). Counselor educators and supervisors could assist counselors in training to develop wellness and self-care strategies. Wellness plans and self-care strategies could be integrated and emphasized during coursework and as a regular part of supervision. Other researchers have supported the implementation of assisting counselors with initiating self-care strategies (e.g. Bourassa, 2012; Harrison & Westwood, 2009; Knight, 2004; Lambert & Lawson, 2013). When counselors in training are educated about the potential to develop vicarious traumatization and posttraumatic growth, and the importance of self-care, counselors will be forewarned, forearmed, and more prepared to sustain wellness and remain in the profession (Walker, 2004).

Supervision was emphasized in both the quantitative and qualitative phases of this study as an important resource in managing the impact of working with clients who have a history of trauma. More specifically, it appears that to have lower levels of vicarious trauma, counselors in training need to have a minimum of 2.5 hours of supervision per week. In addition, supervision has been described as an essential component of healing vicarious traumatization and facilitating posttraumatic growth (Bell, Kulkarni, & Dalton, 2003). Because of these descriptions, it is suggested that supervisors also receive training and be prepared to provide supervision to counselors in training that work with clients

who have a history of trauma. West (2010) suggested supervisors pay attention to parallel process and countertransference during supervision. Supervisors can also employ the use of mindfulness, breathing exercise, and stories to support the wellness of supervisees. The use of mindfulness and breathing exercises can assist supervisees in developing self-awareness skills in the present moment of supervision that transfer to facilitating counseling sessions (Harrison & Westwood, 2009).

Implications for Future Research

The relationship between vicarious traumatization and posttraumatic growth in and across time remains unknown. Researchers have suggested the utility of longitudinal studies in understanding the relationship between exposure to traumatic client stories and the process of vicarious traumatization (Deville, Wright, & Varker, 2009; Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Sabin-Farrell & Turpin, 2003) and the evolution of posttraumatic growth (Cann et al., 2011; Sullivan & Whelan, 2011; Tedeschi & Calhoun, 2004). Linley and Joseph (2007) advocated for future studies to take a longitudinal perspective to better understand the negative and positive impact on counselors working with clients who have experienced trauma. Despite the appeals for future research to evaluate both vicarious traumatization and posttraumatic growth, researchers have not adequately linked these concepts nor examined the development of these constructs overtime. This is unfortunate, as the knowledge of how these constructs develop across time would provide a better understanding of how cumulative exposure to clients who have experienced trauma or other experiences of personal trauma influence the development of vicarious traumatization and posttraumatic growth.

In addition, a longitudinal exploration has the potential to provide information about the early signs of impairment and growth, both of which impact the therapeutic relationship and supports the ethical obligation to do no harm. The knowledge that counselors in training also exhibit vicarious traumatization and posttraumatic growth supports that longitudinal studies begin by obtaining a true baseline during clinical training and follow counselors in training as they progress through their professional career.

Counseling is a proximal process that includes the reciprocal interactions between counselor and client as a therapeutic relationship is established and maintained. Because of this interaction, it is important to understand what aspects of the therapeutic process are impacted when counselors or counselors in training exhibit higher than average levels of vicarious traumatization. For example, how does the age of the client and the client's type of trauma impact the trainee or counselor's level of vicarious traumatization and posttraumatic growth? Another aspect to consider, is evaluating how vicarious traumatization and posttraumatic growth are impacted when counselor or trainee and client have similar trauma experiences in their history. In addition, as counseling is a proximal process between both client and counselor, evaluating the client's perception of the process in conjunction with the counselor's or trainee's level of vicarious traumatization and posttraumatic growth would be beneficial.

Finally, more information is needed to evaluate how having a personal trauma history influences the level of vicarious traumatization and posttraumatic growth among counselors in training. Additional information might include an evaluation of when the

trauma occurred, the frequency of personal trauma experiences, and how the trainee's perception of trauma salience impacts vicarious traumatization and posttraumatic growth. Another area to examine is the possible interaction or moderating effect of personal trauma history and the similarity between counselor personal trauma experiences with client trauma experiences on vicarious traumatization and posttraumatic growth.

In reviewing the current study, and the implications described in preceding sections, it is clear more research is needed to aid in the understanding of how counselors in training are impacted when providing counseling to clients with a trauma history and what contributes to the development of vicarious traumatization and posttraumatic growth.

Limitations

As with all studies, this study too has limitations. Sample size was a limitation that impacted this study. The researcher sought participants from a 17 CACREP institutions nationally to assist in diversifying the sample. However, the researcher received limited information from faculty about the number of eligible participants, which limited the ability to assess response rate. Despite recruiting from 17 institutions, the sample size remained small, which affected the ability to obtain adequate variability in the participants to achieve a moderate effect size. It is also possible that the sample of counselors in training for this study did not provide enough variance across the measures of vicarious traumatization and posttraumatic growth. The range of scores for the current study was 103 to 256. Previous researchers reported a range of 113 to 327 when the

TABS (Pearlman, 2003) were complete by 131 therapists with at least 10 years of experience (Williams et al., 2012).

While an a priori power analysis, with alpha at .05 and a moderate effect size indicated that the current sample size would have been large enough to find a statistically significant effect if one existed in the population; the majority of the analyses revealed small effect sizes. Small effect sizes need larger sample sizes (e.g. 199) to find a statistically significant finding if one exists in the population; therefore, a larger sample is needed when exploring vicarious traumatization and posttraumatic growth among counselor trainees. The resultant low power, due to small effect size, resulted in the inability to find significant differences or relationships for posttraumatic growth on many of the demographic factors (e.g., supervision, personal trauma) and empathy. The study was also limited by the demographic diversity among participants, who were predominantly female and who self-identified as white or Caucasian. In addition, the results are limited due to the inability to generalize findings to counselors in training who are not attending CACREP accredited graduate institutions.

In addressing the limitations of sample size, there are a variety of things to consider. It is possible that counselors in training who attend school full time were not able to designate additional time to participate in a research study. In addition, the use of vicarious traumatization and posttraumatic growth in the recruitment literature may have caused potential participants to become disinterested. Further, counselors in training who may have had a higher level of vicarious traumatization may not have responded while those with lower levels may have considered the study irrelevant to them. It is also

possible that there is a social stigma or social desirability components attached to counselors in training and the perception of being traumatized by their work with clients. There is some concern that the length of the survey may have contributed to the smaller sample size. It was observed that an average of 15 to 20 minutes was needed to complete the entire survey. The researcher recruited at the end of fall semester and again at the beginning of spring semester. A greater number of counselors in training participated at the beginning for spring semester than at the end of fall semester. The researcher employed indirect methods of recruitment and may have had a better response if she had contacted the counselors in training in a more direct manner, such as in person or through direct emails. In a review of study recruitment methods of college students, Sax, Gilmartin, and Bryant (2003) reported greater response rate (24%) among students who were given a paper survey with the option to complete it online compared to a response rate of 19.8% for students who received an email option that included an incentive.

The current study is further limited by the cross sectional nature of the study design. Vicarious traumatization and posttraumatic growth are conceptualized to evolve over time. This study only provided a retrospective view of these constructs from one point of time. The retrospective nature of the study is also a limitation. The semi-structured interviews took place after the counselor in training completed the survey and at times near the end of a semester. This potentially impacted the information that counselors in training shared during interviews. In addition, the use of self-report measures is inherently limited based on participant's memories, attribution, and possible exaggeration. When supervision was examined, only the number of hours was collected,

which limits information pertaining to the quality of the supervision. It is also important to acknowledge that counselors in training provided a retrospective and reflective view of the proximal process and this view did not include the client's perspective.

When evaluating the standardized instruments, adequate reliability coefficients were observed. However, the information gained from the raw scores on the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) is limited and additional information about what subscales exhibited higher scores was not assessed. In addition, the utilization of the PTGI-SF (Cann et al., 2010) instead of the longer version may have limited the variability in the measure and decreased the ability to find a significant result as other researchers who utilized the full scale did report significant results. The exploration of vicarious traumatization and posttraumatic growth, which are both complex constructs, within the same study may have limited the information that could have been obtained if only one construct had been evaluated.

A final limitation is the recognition that researcher bias or loss of objectivity may have influenced the results. This is especially true when completing qualitative analysis, despite steps taken to ensure less subjectivity through the use of a bracketing memo, field journal entries, and auditing. The results are still an extension of the researcher's ideas from conceptualization of the study through the analysis of all results through completion of the study.

Conclusion

In this study, the researcher utilized quantitative and qualitative results to provide a glimpse of the initial experiences of counselors in training when they begin to

empathically engage with clients who have a history of trauma. Through an explanatory mixed methods design to gather both quantitative and qualitative information, a picture of these experiences has been illuminated. What is most clearly illuminated is that counselors in training do indeed exhibit average levels of vicarious traumatization and a moderate degree of posttraumatic growth that is similar to professionals who have worked in the field for at least 10 years. It is imperative that counselor educators and supervisors advise counselors in training and supervisees about the potential risks and benefits that result from working with clients who have a history of trauma. There is also support for mindfulness based stress reduction techniques to be incorporated into the coursework and internship experiences of counseling students. In addition, there are glimmers of information that suggest empathy and supervision account for parts of the variance in the observed levels of vicarious traumatization. The voices of the counselors in training who participated in the qualitative phase echoed the significant contribution supervision has made in managing the impact of working with clients who have a history of trauma and levels of vicarious traumatization.

In moving forward to explore in depth how counselors in training are impacted by their work with clients who have a history of trauma, additional research is warranted. Bronfenbrenner understood the importance of the scientific journey and its vigilance in continuing to change and evolve (Bronfenbrenner, 1999). The challenge to future research is to implement Bronfenbrenner's PPCT research model and CSDT in future study designs so a more comprehensive evaluation of vicarious traumatization and posttraumatic growth can be achieved. In this way, the journey and vigilance of scientific

discovery aspired to by Bronfenbrenner can move forward, evolve, and enhance the understanding of how building therapeutic relationships with clients who have a history of trauma impacts counselors in training and their level of vicarious traumatization and posttraumatic growth.

REFERENCES

- Adams, K. B., Matto, H. C., & Harrington, D. (2001). The Traumatic Stress Institute Belief Scale as a measure of vicarious trauma in a national sample of clinical social workers. *Families in Society*, 82, 363–371.
- American Counseling Association (2005). *ACA code of ethics*. Alexandria, VA: Author.
- American Counseling Association (2014). *ACA code of ethics*. Alexandria, VA: Author.
- Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research*, 9, 407–411.
- Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious post-traumatic growth in psychotherapy. *Journal of Humanistic Psychology*, 45(2), 239–263.
doi:10.1177/10022167805274729
- Arthur, N. M. (1990). The assessment of burnout: A review of three inventories useful for research and counseling. *Journal of Counseling & Development*, 69, 186–189.
doi:10.1002/j.1556-6676.1990.tb01484.x
- Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, 18, 71–86.
- Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counseling Psychology Quarterly*, 19, 181–188.
doi:10.1080/0951507060081189

- Baker, A. A. (2012). Training the resilient psychotherapist: What graduate students need to know about vicarious traumatization. *Journal of Social, Behavioral, and Health Sciences*, 6, 1–12. doi:10.5590/JSBHS.2012.06.1.01
- Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Human Services*, 84, 463–470.
- Ben-Porat, A., & Itzhaky, H. (2009). Implications of treating family violence for the therapist: Secondary traumatization, vicarious traumatization, and growth. *Journal of Family Violence*, 24, 507–515. doi:10.1007/s10896-009-9249-0
- Benatar, M. (2000). A qualitative study of the effect of a history of childhood sexual abuse on therapists who treat survivors of sexual abuse. *Journal of Trauma & Dissociation*, 1, 9–28. doi:10.1300/J229v01n03
- Bensimon, M. (2012). Elaboration on the association between trauma, PTSD and posttraumatic growth: The role of trait resilience. *Personality and Individual Differences*, 52, 782–787. doi:10.1016/j.paid.2012.01.011
- Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention*, 6, 1–9. doi:10.1093/brief-treatment/mhj001
- Boy, A. V., & Pine, G. J. (1980). Avoiding counselor burnout through role renewal. *The Personnel and Guidance Journal*, 59, 161–163. doi:10.1002/j.2164-4918.1980.tb00521.x

- Bourassa, D. (2012). Examining self-protection measures guarding adult protective services social workers against compassion fatigue. *Journal of Interpersonal Violence*, 27, 1699–715. doi:10.1177/0886260511430388
- Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, 30, 386–393. doi:10.1037//0735-7028.30.4.386
- Brandon, J.H. (1999). Working models of self and other in adult attachment and vicarious traumatization. *Dissertation Abstracts International*, 60 (10-B), p. 5219. (University Microfilms No. AAI9949082).
- Branson, D. C., Weigand, D. a., & Keller, J. E. (2013). Vicarious trauma and decreased sexual desire: A hidden hazard of helping others. *Psychological Trauma: Theory, Research, Practice, and Policy*. doi:10.1037/a0033113
- Bresin, K. (2014). Five indices of emotion regulation in participants with a history of nonsuicidal self-injury: a daily diary study. *Behavior Therapy*, 45, 56–66. doi:10.1016/j.beth.2013.09.005
- Bride, B. (2004). The impact of providing psychosocial services to traumatized populations. *Stress, Trauma and Crisis*, 7, 29-64.
- Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, 35, 155–163. doi:10.1007/s10615-007-0091-7

- Brockhouse, R., Msetfi, R. M., Cohen, K., & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: The moderating effects of sense of coherence, organizational support, and empathy. *Journal of Traumatic Stress, 24*, 735–742. doi:10.1002/jts.
- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32*, 513-532.
- Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology, 22*, 723-742.
- Bronfenbrenner, U. (1992/2005). Childcare in Anglo-Saxon mode. In U. Bronfenbrenner (Ed.) *Making human beings human: Bioecological perspectives on human development*. Thousand Oaks: Sage Publishing.
- Bronfenbrenner, U. (1994). Ecological models of human development. In *International Encyclopedia of Education, Vol. 3, 2nd Ed.* Oxford: Elsevier. Reprinted in: Guvain, M. & Cole, M. (Eds.), *Readings on the development of children, 2nd Edition* (1993, pp. 47-43. NY: Freeman.
- Bronfenbrenner, U. (1995). Developmental ecology through space and time: A future perspective. In P. Moen, G. H. Elder, Jr., & K. Luscher (Eds.), *Examining lives in context: Perspectives on the ecology of human development* (pp.619-647). Washington, DC: American Psychological Association.
- Bronfenbrenner, U., & Ceci, S. J. (1994). Nature-nurture reconceptualized in developmental perspective: A bioecological model. *Psychological Review, 101*, 568-586.

- Bronfenbrenner, U. (2005). The bioecological theory of human development. In U. Bronfenbrenner (Ed.), *Making human beings human: Bioecological perspectives on human development* (pp. 3-15). Thousand Oaks, CA: Sage. (Original work published in 2001). Washington, DC: American Psychological Association.
- Bronfenbrenner, U., & Evans, G. (2000). Developmental science in the 21st century: Emerging questions, theoretical models, research designs and empirical findings. *Social Development*, 9(1), 115-125.
- Bronfenbrenner, U., & Morris, P. A. (2006). The bioecological model of human development. In W. Damon (Series Ed.) & R. M. Lerner (Vol. Ed.), *Handbook of child psychology: Vol. 1. Theoretical models of human development* (6th ed., pp. 793-828). New York: John Wiley.
- Bryk, A. S., & Raudenbush, S. W. (1987). Application of hierarchical linear models to assess change. *Psychological Bulletin*, 101, 147-158.
- Calhoun, L. G., Cann, A., Tedeschi, R. G., & McMillan, J. (2000). A correlational test of the relationship between posttraumatic growth, religion, and cognitive processing. *Journal of Traumatic Stress*, 13, 521–527. doi:10.1023/A:1007745627077
- Calhoun, L. G., & Tedeschi, R. G. (1999). *Facilitating posttraumatic growth: A clinician's guide*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Calhoun, L. G., & Tedeschi, R. G. (2004). The foundations of posttraumatic growth: New considerations. *Psychological Inquiry*, 15, 93–102.

- Calhoun, L.G., Tedeschi, R. G., Fulmer, D., & Harlan, D. (2000, August). *Parental grief: The relation of rumination, distress, and posttraumatic growth*. Presented at American Psychological Association Conference, Washington, D. C.
- Canfield, J. (2008). Secondary traumatization, burnout , and vicarious traumatization. *Smith College Studies in Social Work*, 75, 37–41. doi:10.1300/J497v75n02
- Camerlengo, H. (2002). The role of coping style, job-related stress, and personal victimization history in the vicarious traumatization of professionals who work with abused youth. Unpublished doctoral dissertation, Rutgers University, NJ.
- Cann, A., Calhoun, L. G., Tedeschi, R. G., Kilmer, R. P., Gil-Rivas, V., Vishnevsky, T., & Danhauer, S. C. (2010). The Core Beliefs Inventory: A brief measure of disruption in the assumptive world. *Anxiety, Stress, & Coping*, 23, 19–34. doi:10.1080/10615800802573013
- Cann, A., Calhoun, L. G., Tedeschi, R. G., Triplett, K. N., Vishnevsky, T., & Lindstrom, C. M. (2011). Assessing posttraumatic cognitive processes: the Event Related Rumination Inventory. *Anxiety, Stress, and Coping*, 24, 137–56. doi:10.1080/10615806.2010.529901
- Carey, B., Cave, D., & Alvarez, L. (2009, November 8). Painful stories take a toll on military therapists. *New York Times*. Retrieved from: http://www.nytimes.com/2009/11/08/us/08stress.html?pagewanted=1&_r=0
- Chrestman, K. R.. (1995). Secondary exposure to trauma and self reported distress among therapists. In B. H. Stamm (Ed.) *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Maryland: Sidran.

- Christopher, J. C., & Maris, J. A. (2010). Integrating mindfulness as self-care into counseling and psychotherapy training. *Counselling and Psychotherapy Research*, 10, 114–125. doi:10.1080/14733141003750285
- Chun, H., & Dickson, G. (2011). A psychoecological model of academic performance among Hispanic adolescents. *Journal of Youth and Adolescence*, 40(12), 1581–94. doi:10.1007/s10964-011-9640-z
- Clemans, S. E. (2005). Recognizing vicarious traumatization : A single session group model for trauma workers. *Social Work With Groups*, 27, 55–74. doi:10.1300/J009v27n02_05
- Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping*, 23, 319–39. doi:10.1080/10615800903085818
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches*, (3rd ed.). Washington, D. C.: Sage Publications.
- Creswell, J. W., & Clark, V. L. Piano (2011). *Designing and conducting mixed methods research* (2nd Ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Culver, L. M., McKinney, B. L., & Paradise, L. V. (2011). Mental health professionals' experiences of vicarious traumatization in post–Hurricane Katrina New Orleans. *Journal of Loss and Trauma*, 16, 33–42. doi:10.1080/15325024.2010.519279
- Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work*, 48, 451–459. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/14620102>

- Deville, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry*, 43, 373–385.
- Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatization: Current status and future directions. *British Journal of Guidance & Counseling*, 34, 107–116.
doi:10.1080/03069880500483166
- Dutton, M. A., Burghardt, K. J., Perrin, S. G., Chrestman, K. R., & Halle, P. M. (1994). Battered women's cognitive schemata. *Journal of Traumatic Stress*, 7, 237–255.
- Eastwood, C., & Ecklund, K. (2008). Compassion fatigue risk and self-care practices among residential treatment center childcare workers. *Residential Treatment For Children & Youth*, 25, 103–122. doi:10.1080/08865710802309972
- Ebner-Priemer, U. W., & Trull, T. J. (2009). Ecological momentary assessment of mood disorders and mood dysregulation. *Psychological Assessment*, 21, 463–475.
doi:10.1037/a0017075
- Etherington, K. (2000). Supervising counselors who work with survivors of childhood sexual abuse. *Counselling Psychology Quarterly*, 13, 377–389.
doi:10.1080/0951507011003797
- Feinstein, S., Barrtman, J., Buboltz, M., Sonnichsen, K., & Solomon, R. (2008). Resiliency in adolescent males in a correctional facility. *The Journal of Correctional Education*, 59, 94–105.

- Fields, S. K., Mahan, P., Tillman, P., Harris, J., Maxwell, K., & Hojat, M. (2011). Measuring empathy in healthcare profession students using the Jefferson Scale of Physician Empathy: health provider-student version. *Journal of Interprofessional Care*, 25, 287–93. doi:10.3109/13561820.2011.566648
- Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner-Routledge.
- Figley, C. R. (1995b). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.) *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Maryland: Sidran.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology*, 58, 1433–1441.
- Fitzmaurice, G. M., Laird, N. M., & Ware, J. H. (2011). *Applied longitudinal analysis*, (2nd ed.) Hoboken, NJ: John Wiley & Sons, Inc.
- Forney, D. S., Wallace-Schutzman, F., & Wiggers, T. T. (1982). Burnout among career professionals : Preliminary findings. *The Personnel and Guidance Journal*, 435–439.
- Forrest, L., Elman, N. S., & Shen Miller, D. S. (2008). Psychology trainees with competence problems: From individual to ecological conceptualizations. *Training and Education in Professional Psychology*, 2, 183–192. doi:10.1037/1931-3918.2.4.183
- Freudenberger, H. J. (1974). Staff burnout. *Journal of Environmental Issues*, 30, 159-165.

- Gilmartin, S. K. & Bryant, A. N. (2003). Assessing response rates and nonresponse bias in web and paper surveys. *Research in Higher Education*, 44(4), p. 409-432.
- Giller, E., Vermilyea, E., & Steele, T. (2006). Risking connection: Helping agencies embrace relational work with trauma survivors. *Journal of Trauma Practice*, 5, 65–83. doi:10.1300/J189v05n01
- Goldenberg, J. (2002). The impact on the interviewer of holocaust survivor narratives: Vicarious traumatization or transformation? *Traumatology*, 8, 215–231. doi:10.1177/153476560200800405
- Goodman, L. A., & Dutton, M. A. (1996). The relationship between victimization and cognitive schemata among episodically homeless, seriously mentally ill women. *Violence and Victims*, 11, 159–174.
- Hafkenschied, A. (2005). Event countertransference and vicarious traumatization: Theoretically valid and clinically useful concepts? *European Journal of Psychotherapy & Counselling*, 7, 159–168. doi:10.1080/13642530500183804
- Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy Theory, Research, Practice, Training*, 46(2), 203–19. doi:10.1037/a0016081
- Hernández, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies*, 29, 67–83. doi:10.1521/jsyt.2010.29.1.67

- Heppner, P. P., & Heppner, M. J. (2004). *Writing and publishing your thesis, dissertation, and research: A guide for students in the helping professions*. Belmont, CA: Brooks/Cole, Cengage Learning
- Hoffman, M. A., & Kruczek, T. (2011). A bioecological model of mass trauma: Individual, community, and societal effects. *The Counseling Psychologist, 39*, 1087–1127. doi:10.1177/0011000010397932
- Hojat, M. (2007). *Empathy in patient care: Antecedents, development, measurement, and outcomes*. New York: Springer.
- Hojat, M., Gonnella, J. S., Nasca, T. J., Mangione, S., Vergare, M., & Magee, M. (2002). Physician empathy: Definition, components, measurement, and relationship to gender and specialty. *American Journal of Psychiatry, 159*, 1563–1569.
- Hojat, M., Mangione, S., Kane, G., & Gonnella, J. S. (2005). Relationships between scores of the Jefferson Scale of Physician Empathy (JSPE) and the Interpersonal Reactivity Index (IRI). *Medical Teacher, 27*, 625-628.
- Hong, J. S., Lee, C.-H., Lee, J., Lee, N. Y., & Garbarino, J. (2014). A review of bullying prevention and intervention in South Korean schools: An application of the social-ecological framework. *Child Psychiatry and Human Development, 45*(4), 433–42. doi:10.1007/s10578-013-0413-7
- Hooper, L. M., & Britnell, H. B. (2012). Mental health research in K-12 schools: Translating a systems approach to university-school partnerships. *Journal of Counseling & Development, 90*, 81–91.

- Hunter, S. V. (2012). Walking in sacred spaces in the therapeutic bond: Therapists' experiences of compassion satisfaction coupled with the potential for vicarious traumatization. *Family Process, 51*, 179–193.
- Jacobs, S. C., Leach, M. M., & Gerstein, L. H. (2011). Introduction and overview: Counseling psychologists' roles, training, and research contributions to large-scale disasters. *The Counseling Psychologist, 39*(8), 1070–1086.
doi:10.1177/0011000010392245
- Jankoski, J. A. (2012). Vicarious traumatization. In L. L. Levers (Ed.) *Trauma counseling: Theories and interventions* (pp. 540-553). New York: Springer Publisher.
- Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*, 423–432.
doi:10.1023/A:1020193526843
- Jones, K. E., Meneses da Silva, A. M., & Soloski, K. L. (2011). Sexological systems theory: An ecological model and assessment approach for sex therapy. *Sexual and Relationship Therapy, 26*, 127–144. doi:10.1080/14681994.2011.574688
- Jordan, K. (2010). Vicarious trauma: Proposed factors that impact clinicians. *Journal of Family Psychotherapy, 21*, 225–237. doi:10.1080/08975353.2010.529003
- Joseph, S. (2009). Growth following adversity: Positive psychological perspectives on posttraumatic stress. *Psychological Topics, 18*, 335–344.
- Joseph, S., & Butler, L. D. (2010). Positive changes following adversity. *PTSD Research Quarterly, 21*, 1–8.

- Kadambi, M. A., & Truscott, D. (2004). Vicarious Trauma Among Therapists Working with Sexual Violence , Cancer , and General Practice. *Canadian Journal of Counseling, 38*, 260–276.
- Kassam-Adams, N. (1995). The risks of treating sexual trauma: Stress and secondary trauma in therapists. In B. H. Stamm (Ed.) *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Maryland: Sidran.
- Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14*, 32–44. doi:10.1177/1534765608319083
- Kissil, K., Davey, M., & Davey, A. (2013). Foreign-born therapists in the United States: Supervisors' multicultural competence, supervision satisfaction, and counseling self-efficacy. *The Clinical Supervisor, 32*, 185–211.
doi:10.1080/07325223.2013.846746
- Knight, C. (2004). Working with survivors of childhood trauma: Implications for clinical supervision. *The Clinical Supervisor, 23*, 81–106. doi:10.1300/J001v23n02
- Kulkarni, S., Bell, H., Hartman, J., & Herman-Smith, R. (2013). Exploring individual and organizational factors contributing to compassion satisfaction, secondary traumatic stress, and burnout in domestic violence service providers. *Journal of the Society for Social Work and Research, 4*, 114–130. doi:10.5243/jsswr.2013.8
- Lambert, S. F., & Lawson, G. (2013). Resilience of professional counselors following hurricanes Katrina and Rita. *Journal of Counseling & Development, 91*, 261–268.
doi:10.1002/j.1556-6676.2013.00094.x

- Lawson, G., & Myers, J. E. (2011). Wellness, professional quality of life , and career-sustaining behaviors: What keeps us well? *Journal of Counseling & Development*, 89, 163–171.
- Lee, S. M., Baker, C. R., Cho, S. H., Heckathorn, D. E., Holland, M. W., Newgent, R. A., Ogle, N., Powell, M. L., Quinn, J. J., Wallace, S. L., Yu, K. (2007). Development and initial psychometrics of the Counselor Burnout Inventory. *Measurement and Evaluation in Counseling and Development*, 40, 142–155.
- Lee, S. M., Cho, S. H., Kissinger, D., & Ogle, N. T. (2010). A typology of burnout in professional counselors. *Journal of Counseling & Development*, 88, 131–138. doi:10.1002/j.1556-6678.2010.tb00001.x
- Liles, R. G., & Juhnke, G. a. (2008). Adolescent Diabetic Control: Using the Process-Person-Context-Time Model. *Journal of Counseling & Development*, 86(1), 75–84. doi:10.1002/j.1556-6678.2008.tb00628.x
- Linley, P. A., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology*, 26, 385–403. doi:10.1521/jscp.2007.26.3.385
- Linley, P. A., Joseph, S., Cooper, R., Harris, S., & Meyer, C. (2003). Positive and negative changes following vicarious exposure to the September 11 terrorist attacks. *Journal of Traumatic Stress*, 16, 481–485. doi:10.1023/A:1025710528209
- Maher, E. L. (1983). Burnout and commitment: A theoretical alternative. *The Personnel and Guidance Journal*, 61, 390–393. doi:10.1111/j.2164-4918.1983.tb00051.x

- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, NJ: Prentice-Hall.
- Maslach, C. (2003). *Burnout: The cost of caring*. Los Altos, CA: Malor Books.
- Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior*, 2, 99–113.
- Maslach, C., & Leiter (1997). *The truth about burnout: How organizations cause personal stress and what to do about it*. New York: Josey-Bass.
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397–422. doi:10.1146/annurev.psych.52.1397
- McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. New York: Brunner/Mazel.
- McCann, I. L., & Pearlman, L. A. (1990b). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131–149. doi:10.1007/BF00975140
- McNeil, S., & Murphy, L. (2010). Young grandmother caregivers: An ecological perspective for marriage and family therapists. *Journal of Feminist Family Therapy*, 22, 275–292. doi:10.1080/08952833.2010.526055
- Moulden, H. M., & Firestone, P. (2007). Vicarious traumatization: the impact on therapists who work with sexual offenders. *Trauma, Violence & Abuse*, 8, 67–83. doi:10.1177/1524838006297729
- Napoli, M., & Bonifas, R. (2011). From theory toward empathic self-care: Creating a mindful classroom for social work students. *Social Work Education*, 30, 635–649. doi:10.1080/02615479.2011.586560

- National Institute of Mental Health. (2006). *Helping children and adolescents cope with violence and disasters: What parents can do*. (DHHS Publication No. 07-3518). Washington D. C.: U. S. Government Printing Office.
- Parker, M., & Henfield, M. S. (2012). Exploring school counselors ' perceptions of vicarious trauma: A qualitative study. *The Professional Counselor: Research and Practice*, 2, 134–142.
- Pearlman, L. A. (1996). Psychometric review of TSI Belief Scale, Revision L. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 415–417). Lutherville, MD: Sidran.
- Pearlman, L. A. (2003). *Trauma and attachment belief scale*. Los Angeles, CA: Western Psychological Services.
- Pearlman, L. A. (2008). Trauma and the self: A theoretical and clinical perspective. *Journal of Emotional Abuse*, 1, 37–41. doi:10.1300/J135v01n01
- Pearlman, L. A., & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress*, 18, 449–459. doi:10.1002/jts.20052
- Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26(6), 558–565. doi:10.1037//0735-7028.26.6.558
- Pearlman, L. A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton.

- Pearlman, L. A., & Saakvitne, K. W. (1995b). Treating therapists with vicarious traumatization and secondary traumatic stress disorders (pp. 150-177). In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Bristol, PA: Brunner/Mazel.
- Rasmussen, B. (2005). An intersubjective perspective on vicarious trauma and its impact on the clinical process. *Journal of Social Work Practice, 19*, 19–30.
doi:10.1080/02650530500071829
- Rogers, C. (1942). *Counseling and psychotherapy: Newer concepts in practice*. Boston: Houghton Mifflin.
- Rogers, C. (1959). A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.) *Psychology: A study of a science Vol. 3, Formulations of the person and the social context* (pp. 184-256). New York: McGraw Hill.
- Rosenbloom, D. J., Pratt, A. C. & Pearlman, L. A. (1995). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. H. Stamm (Ed.) *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Maryland: Sidran.
- Ross, R. R., Altmaier, E. M., & Russell, D. W. (1989). Job stress, social support, and burnout among counseling center staff. *Journal of Counseling Psychology, 36*, 464–470. doi:10.1037//0022-0167.36.4.464

- Roysircar, G., & Pignatiello, V. (2011). A multicultural-ecological assessment tool: Conceptualization and practice with an Asian Indian immigrant woman. *Journal of Multicultural Counseling and Development, 39*, 167–180.
- Saakvitne, K. W. (2002). Shared trauma: The therapist's increased vulnerability. *Psychoanalytic Dialogues: The International Journal of Relational Perspectives, 12*, 443–449. doi:10.1080/10481881209348678
- Saakavitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton & Company.
- Saakvitne, K. W., Tennen, H., & Affleck, G. (1998). Exploring thriving in the context of clinical trauma theory: Constructivist self development theory. *Journal of Social Issues, 54*, 279–299. doi: 10.1111/j.1540-4560.1998.tb01219.x
- Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review, 23*, 449–480. doi:10.1016/S0272-7358(03)00030-8
- Saylor, C. (1993). Children and disasters: Clinical and research issues. In C. Saylor (Ed.) *Children and Disasters* (pp. 1-10). New York, NY: Plenum Press.
- Savaki, V., & Cooley, E. J. (1982). Implications of burnout research and theory for counselor educators. *The Personnel and Guidance Journal, 60*, 415–419. doi:10.1002/j.2164-4918.1982.tb00789.x
- Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors working with sexual violence survivors. *Psychology of Women Quarterly, 19*, 49–64. doi:10.1111/j.1471-6402.1995.tb00278.x

- Sexton, L. (1999). Vicarious traumatization of counselors and effects on their workplaces. *British Journal of Guidance & Counselling*, 27, 393–403.
doi:10.1080/03069889908256279
- Shen-Miller, D. S., Isacco, A., Davies, J. A., Jean, M. S., & Phan, J. L. (2013). The men's center approach: Ecological interventions for college men's health. *Journal of Counseling & Development*, 91, 499–508. doi:10.1002/j.i
- Skovholt, T. M., & Ronnestad, M. H. (1992). Themes in therapist and counselor development. *Journal of Counseling and Development*, 70, 505-515.
- Skovholt, T. M., & Ronnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development*, 30, 45–58.
doi:10.1177/089484530303000103
- Sommer, C. A. (2008). Vicarious traumatization, trauma-sensitive supervision, and counselor preparation. *Counselor Education & Supervision*, 48, 61–72.
- Sommer, C. A., & Cox, J. A. (2005). Supervision elements of supervision in sexual violence counselors' narratives: A qualitative analysis. *Counselor Education & Supervision*, 45, 119–134.
- Sommer, C. A., & Cox, J. a. (2006). Sexual violence counselors' reflections on supervision: Using stories to mitigate vicarious traumatization. *Journal of Poetry Therapy: The Interdisciplinary Journal of Practice, Theory, Research and Education*, 19, 3–16. doi:10.1080/08893670600565587

- Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma: International Perspectives on Stress and Coping*, 12, 259–280. doi:10.1080/15325020701238093
- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. In C. R. Figley (Ed.), *Treating compassion fatigue*. New York: Brunner-Routledge.
- Stamm, B. H. (2010). *The concise ProQol manual, 2nd Ed.* Pocatello, ID: ProQol.or
- Stone, A. A., & Shiffman, S. (1994). Ecological momentary assessment (EMA) in behavioral medicine. *Annals of Behavioral Medicine*, 16, 199–202.
- Shiffman, S., Stone, A. a., & Hufford, M. R. (2008). Ecological momentary assessment. *Annual Review of Clinical Psychology*, 4, 1–32. doi:10.1146/annurev.clinpsy.3.022806.091415
- Substance Abuse and Mental Health Services Administration (2012). *Trauma definition: Part one defining trauma*. Retrieved from: <http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx>
- Sullivan, J. O., & Whelan, T. A. (2011). Adversarial growth in telephone counsellors: Psychological and environmental influences. *British Journal of Guidance & Counseling*, 39, 307–324. doi:10.1080/03069885.2011.567326
- Tabachnick, B. G., & Fidell, L. S. (2007). *Using Multivariate Statistics* (5th ed.). Boston: Pearson Education, Inc.

- Taku, K., Cann, A., Calhoun, L. G., & Tedeschi, R. G. (2008). The factor structure of the Posttraumatic Growth Inventory: A comparison of five models using confirmatory factor analysis. *Journal of Traumatic Stress, 21*, 158–164. doi:10.1002/jts.
- Tedeschi, R. G. (1999). Violence Transformed: Posttraumatic growth in survivors and their societies. *Aggression and Violent Behavior, 4*, 319–341. doi: 10.1002/jclp.10117
- Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 455–471. doi:10.1007/BF02103658
- Tedeschi, R.G., & Calhoun, L.G. (2004). A clinical approach to posttraumatic growth. In P. A. Linley & S. Joseph (Eds.), *Positive psychology in practice* (pp. 405-419). Hoboken, NJ: Wiley.
- Tiedeman, D. V. (1979). Burning and copping out of counseling. *The Personnel and Guidance Journal, 57*, 328–330. doi:10.1002/j.2164-4918.1979.tb05404.x
- Trippany, R. L. (2000). Predictors of vicarious traumatization: Female therapists for adult survivors versus female therapists for child survivors of sexual victimization. Unpublished doctoral dissertation: University of Alabama.
- Trippany, R. L., Kress, V. E. White, & Wilcoxin, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development, 82*, 31–37.

- Trippany, R. L., Wilcoxon, S. A., & Satcher, J. F. (2003). Factors influencing vicarious traumatization for therapists of survivors of sexual victimization. *Journal of Trauma Practice*, 2, 47–60. doi:10.1300/J189v02n01
- Tudge, J. (2008). Cultural-ecological theory and its implications for research (Chapter 3) in J. Tudge (Ed.) *The everyday lives of young children*. Cambridge University Press. Kindle Edition.
- Tuma, F. (2013, May 30). *Post-traumatic stress disorder: Heterogeneity and translation*. Retrieved from <http://www.nimh.nih.gov/funding/grant-writing-and-application-process/concept-clearances/2013/post-traumatic-stress-disorder-heterogeneity-and-translations.html>
- Tyler, T. A. (2012). The limbic model of systemic trauma. *Journal of Social Work Practice : Psychotherapeutic Approaches in Health, Welfare and the Community*, 26, 125–138. doi:10.1080/02650533.2011.602474
- United Nations Department of Economics and Social Affairs (July 2010). *Environmental indicators: Natural disasters*. Retrieved February 20, 2013, from: <http://unstats.un.org/unsd/environment/qindicators.htm>.
- Van der Kolk (1987). *Psychological trauma*. Washington DC: American Psychiatric Press.
- Varra, E. M., Pearlman, L. A., Brock, K. J., & Hodgson, S. T. (2008). Factor analysis of the trauma and attachment belief scale: A measure of cognitive schema disruption related to traumatic stress. *Journal of Psychological Trauma*, 7(3), 185–196. doi:10.1080/19322880802266813

- Vrklevski, L. P., & Franklin, J. (2008). Vicarious trauma: The impact on solicitors of exposure to traumatic material. *Traumatology, 14*, 106–118.
doi:10.1177/1534765607309961
- Walker, M. (2004). Supervising practitioners working with survivors of childhood abuse: countertransference; secondary traumatization and terror. *Psychodynamic Practice: Individuals, Groups and Organisations, 10*, 173-194.
- Warnath, C. F. (1979). Counselor burnout: Existential crisis or a problem for the profession? *The Personnel and Guidance Journal, 57*, 325–328.
- Warren, J., Morgan, M., Morris, L. B., & Morris, T. M. (2010). Breathing words slowly: Creative writing and counselor self-care—the writing workout. *Journal of Creativity in Mental Health, 5*, 109–124. doi:10.1080/15401383.2010.485074
- Watkins Jr., C. E. (1983). Burnout in counseling practice: Some potential professional and personal hazards of becoming a counselor. *The Personnel and Guidance Journal, 61*, 304–308. doi:10.1111/j.2164-4918.1983.tb00031.x
- Wells, M., Trad, A., & Alves, M. (2003). Training beginning supervisors working with new trauma therapists: A relational model of supervision. *Journal of College Student Psychotherapy, 17* (3), 19–39. doi:10.1300/J035v17n03
- Wenze, S. J., & Miller, I. W. (2010). Use of ecological momentary assessment in mood disorders research. *Clinical Psychology Review, 30*(6), 794–804.
doi:10.1016/j.cpr.2010.06.007

- West, A. (2010). Supervising counselors and psychotherapists who work with trauma: A Delphi study. *British Journal of Guidance & Counselling*, 38, 409–430.
doi:10.1080/03069885.2010.503696
- Westphal, M., & Bonanno, G. a. (2007). Posttraumatic growth and resilience to trauma: Different sides of the same coin or different coins? *Applied Psychology: An International Review*, 56(3), 417–427. doi:10.1111/j.1464-0597.2007.00298.x
- Williams, A., Helm, H., Clemens, E. (2012). The effect of childhood trauma, personal wellness, supervisory working alliance and organizational factors on vicarious traumatization. *Journal of Mental Health Counseling*, 34, 133–153.
- Woodson, K. M., Hives, C., & Sanders-Phillips, K. (2010). Violence exposure and health related risk among African American adolescent female detainees: A strategy for reducing recidivism. *Journal of Offender Rehabilitation*, 49, 571–584.
doi:10.1080/10509674.2010.519669
- Young, C. M. (1999). *Vicarious trauma in psychotherapists who work with physically or sexually abused children*. (Unpublished doctoral dissertation). The California School of Professional Psychology, Alameda.

APPENDIX A
INFORMED CONSENT

	Page
PHASE 1: INFORMED CONSENT	207
PHASE 2: INFORMED CONSENT	211

PHASE 1: INFORMED CONSENT

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT TO ACT AS A HUMAN PARTICIPANT

Project Title: Phase 1: *A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training*

Principal Investigator and Faculty Advisor: Tamarine M. Foreman, MEd, NCC,
Principal Investigator; Kelly Wester, PhD, Faculty Advisor

What are some general things you should know about research studies?

You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or the University of North Carolina at Greensboro.

Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study. You may print this consent form for your records by printing this form before you move forward. If you have any questions about this study at any time, you should ask the researchers named in this consent form. Their contact information is below.

What is the study about?

This is a research project. Your participation is voluntary. The purpose of this study is to better understand the initial experiences of counselors in training as they begin seeing clients, especially those seeing clients who have a history of trauma.

Why are you asking me?

You are being asked to participate because you are 1) at least 20 years old; 2) attending a master's level graduate counseling program that has received or applied for CACREP accreditation; and 3) you are currently enrolled in a 100-hour practicum or 600-hour internship.

What will you ask me to do if I agree to be in the study?

The study will ask you to complete a demographics questionnaire and survey. It is

estimated to take approximately 20-30 minutes to complete the initial survey. You will also have the option to volunteer to be selected as a participant for a semi-structured interview facilitated by the primary investigator, which is estimated to take a minimum of 45 minutes to a maximum of 90 minutes. It is possible, though unlikely, that questions on the surveys may cause minimal emotional stress.

If you have questions or concerns about your level of participation, please contact the primary investigator, Tamarine Foreman by phone (336) 334-3423, or email tmforema@uncg.edu.

What are the risks to me?

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. The minimal risks may include emotional reactions to questions on the surveys and are not expected to require medical or psychological treatment. Please know you have the option not to respond to any questions that cause you to feel uncomfortable or emotionally distressed.

If you feel any emotional distress, you are encouraged to seek counseling from a qualified professional. The following online database of counselors can assist you in locating a qualified professional: <http://www.nbcc.org/CounselorFind>.

If you have questions, want more information or have suggestions, please contact Tamarine Foreman at (336) 334-3423 or email at tmforema@uncg.edu or faculty advisor Kelly Wester, PhD at klwester@uncg.edu.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

Are there any benefits to society as a result of *me* taking part in this research? Your participation may assist counselors in training, counselors, counselor educators, and supervisors to address the impact of vicarious traumatization and post-traumatic growth. It is hoped the research will lead to a better understanding of how to better train and support counselors in training.

Are there any benefits to *me* for taking part in this research study? There are no direct benefits to participants in this study.

Will I get paid for being in the study? Will it cost me anything?

There are no costs to you for participating in this study. All participants who complete the survey will receive a list of wellness resources. The first 100 participants to complete the survey will receive a \$5 e-gift card to their choice of Amazon.com, Starbucks, Target, or Panera. If you complete the survey and volunteer to be selected as a possible participant in a phase two semi- structured interview, you will receive a copy of your survey results. Participants who complete the semi-structured interview will receive a \$10 e-gift card to their choice of Amazon.com, Starbucks, Target, or Panera.

How will you keep my information confidential?

The information you share will be kept confidential. Confidential data collection procedures have been put into place. The Qualtrics online web tool meets the strictest confidentiality standards and is in full compliance with HIPPA. Toward the end of the study and once data collection has been completed, all identifying information, such as email addresses, that were collected for distribution purposes will be removed from all databases and replaced with a randomly created id number.

All information obtained from surveys will be stored in password protected files and password protected folders on a password protected computer. Any identifying information will be maintained separate from response data in a password protected file on a password protected computer. When the password protected computer is not in use, it will be stored behind a locked door. All information obtained in this study is strictly confidential unless disclosure is required by law.

Please also note that absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing.

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data, which has been collected be destroyed unless it is in a de-identifiable state. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

What about new information/changes in the study?

If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Voluntary Consent by Participant:

By signing this consent form you are agreeing that you read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By signing this form, you are agreeing that you are 20 years of age or older and are agreeing to participate.

Signature: _____ Date: _____

Online Electronic Consent:

☐ Yes, I have read and understood the consent form and voluntarily consent to participate in this study.

☐ No, I do not wish to participate in this study.

UNCG IRB
Approved Consent Form
Valid from:
11/5/14 to **9/21/15**

PHASE 2: INFORMED CONSENT

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT TO ACT AS A HUMAN PARTICIPANT

Project Title: Phase 2 (Semi-Structured Interviews): *A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training*

Principal Investigator and Faculty Advisor (if applicable): Tamarine M. Foreman, MEd, NCC, Principal Investigator; Kelly Wester PhD, Faculty Advisor

What are some general things you should know about research studies?

You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or the University of North Carolina at Greensboro. Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study.

You may print this consent form for your records by printing this form before you move forward. If you have any questions about this study at any time, you should ask the researchers named in this consent form. Their contact information is below.

What is the study about?

This is a research project. Your participation is voluntary. The purpose of this study is to better understand your initial experiences as a counselor in training as you begin seeing clients, especially those clients who have a history of trauma. It is also to explore any change or lack of change that occurred on the surveys you completed.

Why are you asking me?

You are being asked to participate because you are 1) at least 20 years old; 2) attending a master's level graduate counseling program that has received or applied for CACREP accreditation; and 3) you are currently enrolled in a practicum or internship; 4) you have completed the initial survey and subsequent surveys; 5) you have volunteered to be selected as a participant in the semi-structured interview; 6) your scores on the surveys have demonstrated interesting results as demonstrated in comparing survey scores.

What will you ask me to do if I agree to be in the study?

The second phase of the study will select participants who have volunteered to complete a semi-structured interview, estimated to take a minimum of 45 minutes to a maximum of 90 minutes. It is possible, though unlikely, that the interview may cause minimal emotional stress.

If you have questions or concerns about your level of participation, please contact the primary investigator, Tamarine Foreman by phone (336) 334-3423, or email tmforema@uncg.edu.

Is there any audio/video recording?

If you consent to continue participating, you will have the opportunity to be selected as a voluntary participant to complete a semi-structured interview that will be audio recorded. Please know that because your voice will be potentially identifiable by anyone who hears the tape, your confidentiality for things you say on the tape cannot be guaranteed although the researcher will try to limit access to the tape as described below in the confidentiality section.

What are the risks to me?

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. The minimal risks may include emotional reactions to questions on the surveys and are not expected to require medical or psychological treatment. Please know you have the option not to respond to any questions that cause you to feel uncomfortable or emotionally distressed.

If you feel any emotional distress, you are encouraged to seek counseling from a qualified professional. The following online database of counselors can assist you in locating a qualified professional: <http://www.nbcc.org/CounselorFind>.

If you have questions, want more information or have suggestions, please contact Tamarine Foreman at (336) 334-3423 or email at tmforema@uncg.edu or faculty advisor Kelly Wester, PhD at klwester@uncg.edu.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

Are there any benefits to society as a result of *me* taking part in this research?

Your participation may assist counselors in training, counselors, counselor educators, and supervisors to address the impact of vicarious traumatization and post-traumatic growth. It is hoped the research will lead to a better understanding of how to better train and support counselors in training.

Are there any benefits to *me* for taking part in this research study?

There are no direct benefits to participants in this study. However, participants in this phase of the study will be provided their written and graphical results from the surveys and have the opportunity to discuss these results.

Will I get paid for being in the study? Will it cost me anything?

Participants who voluntarily complete the semi-structured interview will receive an e-gift card valued at \$10 to their choice of Amazon.com, Starbucks, Target, or Panera.

How will you keep my information confidential?

The information you share will be kept confidential. The interview will be audio recorded on a digital device and transferred to a password protected file on a password protected computer then deleted from the digital device. Only the primary researcher will listen to the audio recording. Participants will be given pseudonyms to protect their confidentiality. Any narrative of the interview will not contain personal identifying information. At the end of the study all audio recordings will be deleted from the password protected files on the password protected computer.

All information obtained from surveys will be stored in password protected files and password protected folders on a password protected computer. Any identifying information will be maintained separate from response data in a password protected file on a password protected computer. When the password protected computer is not in use, it will be stored behind a locked door. All information obtained in this study is strictly confidential unless disclosure is required by law.

Please also note that absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing.

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

What about new information/changes in the study?

If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Online Electronic Consent:

- Yes, I have read and understood this consent form and voluntarily consent to participate in this phase of the study and complete an interview.

My email address is : _____

- No, I do not wish to participate in this phase of the study.

UNCG IRB
Approved Consent Form
Valid from:

11/5/14 to 9/21/15

APPENDIX B
INSTRUMENTATION FOR PHASE 1

	Page
DEMOGRAPHIC QUESTIONNAIRE	216
PERMISSION TO USE TRAUMA ATTACHMENT BELIEFS SCALE.....	223
PERMISSION TO USE POSTTRAUMATIC GROWTH INVENTORY SHORT FORM	225
POSTTRAUMATIC GROWTH INVENTORY – SHORT FORM.....	226
PERMISSION TO USE THE JEFFERSON SCALE OF EMPAHTY FOR HEALTH PROFESSION STUDENTS	228

DEMOGRAPHIC QUESTIONNAIRE

1. In what state do you reside? (Dropdown box provided)
2. What is your current age? _____
3. Gender:
 - ☐ Male
 - ☐ Female
 - ☐ Other: _____
4. Please select one of the following for ethnicity: (*Ethnicity and Race categories provided by the US Office of Management and Budget developed in 1997).
 - ☐ Hispanic or Latino
 - ☐ Not Hispanic nor Latino
5. Please indicate one or more races that apply to you:
 - ☐ American Indian or Alaskan Native
 - ☐ Asian
 - ☐ Black or African American
 - ☐ Native Hawaiian or Other Pacific Islander
 - ☐ White
 - ☐ Other: _____
6. Relationship Status: (please select the best answer)
 - ☐ Single
 - ☐ Dating
 - ☐ Partnered without children
 - ☐ Partnered with children
 - ☐ Married without children
 - ☐ Married with children
 - ☐ Divorced
 - ☐ Widowed
 - ☐ Other: _____

7. What degree are you pursuing?

- ☐ MS
- ☐ MS Ed.
- ☐ PhD
- ☐ Other _____

8. Do you attend graduate school: (select one)

- ☐ Part time
- ☐ Full time

9. You are currently a Student enrolled in and completing hours for: (please select answer)

- ☐ Practicum (100 hour, encompassing direct and indirect client hours)
- ☐ Internship (300 hour, encompassing direct and indirect client hours)

10. What Counseling Track(s) are you in? (select all that apply)

- ☐ Addiction Counseling
- ☐ Career Counseling
- ☐ Clinical Mental Health Counseling
- ☐ Clinical Rehabilitation Counseling
- ☐ Marriage, Couple & Family Counseling
- ☐ Postsecondary Counseling
- ☐ School Counseling
- ☐ Student Affairs and College Counseling
- ☐ Other: _____

11. How many credit hours have you completed in your Counseling Program?

- ☐ 1-10 credit hours
- ☐ 11-20 credit hours
- ☐ 21-30 credit hours
- ☐ More than 31 credit hours

12. The setting of your Practicum and/or Internship is:

- ☐ College
- ☐ School
- ☐ Outpatient
- ☐ Intensive Outpatient
- ☐ Partial-hospitalization
- ☐ Inpatient
- ☐ Residential
- ☐ Other: _____

13. The primary age of clients or students at your practicum and/or internship are:

- ☐ Young children (ages 2-4)
- ☐ School Aged Children (ages 5-11)
- ☐ Adolescents (12-18)
- ☐ Young Adults (18-24)
- ☐ Adults (25-64)
- ☐ Older and Elderly Adults (65 + years)
- ☐ Other: _____

14. How many clients are on your current caseload? Please select from the dropdown box.

15. Of the clients you have seen this semester, approximately how many have a history of trauma? Trauma is defined as an event, series of events, or set of circumstances experienced by an individual or a group that can cause physical and/or psychological stress reactions that is experienced by an individual as physically or emotionally harmful, threatening, or overwhelming and has lasting adverse effects on the individuals physical, social, emotional, or spiritual well-being. Please select the number from the dropdown box.

*If 0 selected, then skip to question 17.

16. Please select what traumatic event(s) your clients have reported experiencing. Please select all that apply.

- ☐ Automobile accident
- ☐ Childhood physical abuse
- ☐ Childhood sexual abuse
- ☐ Childhood neglect
- ☐ Date rape
- ☐ Death of a loved one
- ☐ Diagnosis of disease/disability

- ☐ Divorce
- ☐ Domestic violence
- ☐ Miscarriage
- ☐ Military combat or war zone
- ☐ Natural Disaster
- ☐ Physical Assault
- ☐ Rape
- ☐ Robbery
- ☐ Torture
- ☐ Other: _____

17. On average, how many total hours do you receive of supervision each week?

- ☐ 30 minutes
- ☐ 1 hour
- ☐ 2 hours
- ☐ 3 hours
- ☐ Other: _____
- ☐ None

18. Do you receive supervision from: (please select all that apply)

- ☐ University Faculty Supervisor
- ☐ University Doctoral Supervisor
- ☐ Practicum or Internship Site supervisor
- ☐ Other: _____

19. Do you receive supervision: (please select all that apply)

- ☐ Weekly
- ☐ Twice a month
- ☐ Once a month
- ☐ Individually
- ☐ Group
- ☐ Triadic

STANDARDIZED MEASURES PRESENTED IN THIS ORDER:

JSE-HP-S

PTGI-SF

TABS

18. Have you ever experienced a traumatic event(s)? Trauma is defined as an event, series of events, or set of circumstances experienced by an individual or a group that can cause physical and/or psychological stress reactions that is experienced by an individual as physically or emotionally harmful, threatening, or overwhelming and has lasting adverse effects on the individuals physical, social, emotional, or spiritual well-being.

- ☐ Yes
- ☐ No

If No Is Selected, Then Skip To End of Block

If Yes: Please check the traumatic event or events you have experienced: (please select all that apply)

- ☐ Automobile accident
- ☐ Childhood physical abuse
- ☐ Childhood sexual abuse
- ☐ Date rape
- ☐ Death of a loved one
- ☐ Diagnosis of disease/disability
- ☐ Divorce
- ☐ Domestic violence
- ☐ Miscarriage
- ☐ Military combat or war zone
- ☐ Natural Disaster
- ☐ Physical Assault
- ☐ Rape
- ☐ Robbery
- ☐ Torture
- ☐ Other: _____

Thank you for your assistance with this study. As a follow-up, I will be conducting individual interviews with selected participants who volunteer as a potential participant. The interviews are anticipated to take 45 to 90 minutes. All participants who volunteer to be a possible interview participant will receive a copy of their survey results. If you would like to volunteer to be selected as an interview participant and receive your survey results, please provide your email below.

- ☐ My email address is: _____
- ☐ No, thank you.

If No, thank you. Is Selected, Then Skip To End of Block

Thank you for completing this survey. As a token of appreciation, you are eligible to receive a \$5 e-gift card to one of the following places. Please select what gift card you would like to receive. Also be sure to enter your email address so I may send you the gift card.

- ☐ Image:Amazon
- ☐ Image:Panera
- ☐ Image:Target
- ☐ Image:Starbucks

Please send my \$5 e-gift card to my following email address:

Thank you for your assistance with this research. As a token of my appreciation, here are some wellness resources to assist you in your continued journey. Please feel free to print these resources.

PERMISSION TO USE TRAUMA ATTACHMENT BELIEFS SCALE

wps®
Western Psychological Services
A Division of Manson Western Corporation
625 Alaska Avenue
Torrance, CA 90503-5124
www.wpspublish.com

September 4, 2014

Tamarine M. Foreman, MEd, NCC, LPCC-s (Ohio)
The University of North Carolina at Greensboro
Department of Counseling & Educational Development
228 Curry Building, PO Box 26170
Greensboro, NC 27402-6170

Re: Trauma and Attachment Scale (TABS), Adult Form

Hello—

WPS has processed your license for a specific web-based application of TABS material. By surface mail, you will soon receive a paid-in-full WPS receipt, which serves as your license to a) adapt the format of the TABS items for administration via a secure, password-protected, on-line environment, and to b) conduct database-style scoring of the instrument, using guidelines derived from our copyrighted scoring key up to three hundred (300) times total. This authorization is for sole use in your registered, scholarly study, "Touched by Trauma: A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training"—with no authorization for continued or commercial use—subject to the provisions of terms and conditions provided to you August 13, 2014.

With reference to condition (4) of WPS's August 13th terms letter, please affix the following copyright notice in its entirety, on the screen of item presentation, to each archived reprint/viewing of the TABS:

Material from the TABS copyright © 2003 by Western Psychological Services. Format adapted by T. Foreman, The University of North Carolina at Greensboro, for specific, limited research use under license of the publisher, WPS, 625 Alaska Avenue, Torrance, California 90503, U.S.A. (rights@wpspublish.com). No additional reproduction, in whole or in part, by any medium or for any purpose, may be made without the prior, written authorization of WPS. All rights reserved.

On behalf of WPS, I hope the TABS well serves your study, and look forward in due course to learning of your research results.

Sincerely yours,



Sandra I. Ceja
WPS Rights & Permissions Assistant
e-mail: sceja@wpspublish.com

SC:sc

wps®
Western Psychological Services
A Division of Manson Western Corporation
625 Alaska Avenue
Torrance, CA 90503
www.wpspublish.com

Dear Graduate Student:

Thank you for contacting Western Psychological Services for permission to reprint copyrighted test material within an appendix of your dissertation. When widely-distributed commercially produced tests are used, guidelines at most research universities do not call for inclusion of full instruments in thesis or dissertation volumes. In such cases, university policies are generally sensitive to the threat to commercial copyright and proprietary interests that is implicit in such copying or redistributing materials. The inclusion of instruments is generally limited to use of materials that are original to the dissertation author or that are otherwise unpublished and so might be considered difficult for subsequent readers to obtain.

As a publisher of formally developed test materials, WPS policy in such matters is to not authorize reprinting of our tests, subtests, or scales in their entirety, unless there is a committee requirement or other research-based reason that (1) requires you to reprint a test, subtest or scale in its entirety, and that (2) prevents the inclusion in your dissertation of original test forms. We can, as an alternative, readily provide authorization the reproduction of up to five representative sample items from the instrument upon receipt of your written request to that effect, including the specific item numbers desired for reprint. Also, if you need to reprint any other material from the test, including and not limited to material from the instrument's manual, please provide details by page, figure, table numbers, etc., for our consideration in authorizing inclusion of that material within your work.

If you need to pursue reprinting of the instrument in its entirety, please write again to WPS Rights and Permissions: Provide us with the reason you must reprint the subtests in their entirety (as opposed to selecting representative sample items); explain specifically why you are required to reproduce the original subtest (as opposed to binding an original protocol); and arrange for a supervising faculty member to co-sign the request. For expedience, please note that you may fax the letter to my attention at 424/201-6950, or have your professor e-mail it to me through his/her university e-mail address. For your additional reference in the event that your dissertation will be microfilmed, WPS will not authorize reproduction of our tests by microfilm, due to the public availability of the medium. While we regret any inconvenience our position may cause, we hope you appreciate our concern with ethical considerations.

We appreciate your interest in our material, as well as your consideration for its copyright. Please contact me if you have any questions.

Sincerely yours,

Susan Dunn Weinberg
WPS Rights and Permissions Manager
e-mail: weinberg@wpspublish.com

SDW:se

**PERMISSION TO USE POSTTRAUMATIC GROWTH INVENTORY SHORT
FORM**

Posttraumatic Growth <PosttraumaticGrowth@uncc.edu>

Mon, Jul 28, 2014 at
10:54 AM

To: Tamarine Foreman <tmforema@uncg.edu>

Hello,

Thanks for your work and interest in PTG. We welcome the use of our scales in academic, not-for-profit research such as yours.

Our inventories and instructions for use are attached.

Best wishes,

Posttraumatic Growth Research Center

UNC Charlotte

Department of Psychology

9201 University City Blvd

Charlotte, NC 28223-0001 USA

Lawrence G. Calhoun (lcalhnjr@uncc.edu)

Richard G. Tedeschi (rtedesch@uncc.edu)

Arnie Cann (acann@uncc.edu)

www.ptgi.uncc.edu

<http://www.routledgejournalofmentalhealth.com/books/details/9780415645300/>.

POSTTRAUMATIC GROWTH INVENTORY – SHORT FORM

Posttraumatic Growth Inventory –SF (Short Form)

Indicate, for each of the statements below, the degree to which the stated change occurred in your life as a result of working with clients, using the following scale.

- 0= I did not experience this change as a result of my crisis.
1= I experienced this change to a very small degree as a result of my crisis.
2= I experienced this change to a small degree as a result of my crisis.
3= I experienced this change to a moderate degree as a result of my crisis.
4= I experienced this change to a great degree as a result of my crisis.
5= I experienced this change to a very great degree as a result of my crisis.

1. I changed my priorities about what is important in life. (V-1)
2. I have a greater appreciation for the value of my own life. (V-2)
3. I am able to do better things with my life. (II-11)
4. I have a better understanding of spiritual matters. (IV-5)
5. I have a greater sense of closeness with others. (I-8)
6. I established a new path for my life. (II-7)
7. I know better that I can handle difficulties. (III-10)
8. I have a stronger religious faith. (IV-18)
9. I discovered that I'm stronger than I thought I was. (III-19)
10. I learned a great deal about how wonderful people are. (I-20)

Note: Scale is scored by averaging all responses. Factors can be scored by adding responses to items on each factor. Caution should be used when using factor scores based on only two items. When using the PTGI-SF the total score should be used, rather than factor scores. Items to which factors belong are not listed on the form administered to participants. Number in parentheses with Factor is the item number from the original PTGI.

PTGI Factors

Factor I: Relating to Others
Factor II: New Possibilities
Factor III: Personal Strength
Factor IV: Spiritual Change
Factor V: Appreciation of Life

Cann, A., Calhoun, L. G., Tedeschi, R. G., Taku, K., Vishnevsky, T., Triplett, K. N., & Danhauer, S. C. (2010). A short form of the Posttraumatic Growth Inventory. *Anxiety, Stress, & Coping*, 23(2), 127-137.

**PERMISSION TO USE THE JEFFERSON SCALE OF EMPAHTY FOR
HEALTH PROFESSION STUDENTS**

(JSE-HP-S)

empathy svc <empathy@jefferson.edu>

Wed, Aug 20, 2014 at 5:35 PM

To: Tamarine Foreman <tmforema@uncg.edu>

Cc: Mohammadreza Hojat <Mohammadreza.Hojat@jefferson.edu>

Hi Tamarine,

With your agreement to all conditions stated in our previous emails, you have our permission to make 100copies of the JSE HPS-version for the single not-for-profit study that you described. I have attached a copy of the scale, the User's Guide and the scoring algorithm.

We wish you luck with your research! Please keep us informed of your progress.

Kind regards,

Kaye

Kaye Maxwell

Empathy Projects

Thomas Jefferson University

Center for Research in Medical Education and Health Care

Phone: 215-955-6907

Cell: 610-639-6823 (preferred)

<http://www.jefferson.edu/university/jmc/crmehc/jse.html>

APPENDIX C
INTERVIEW PROTOCOL FOR PHASE 2

	Page
SEMI-STRUCTURED INTERVIEW PROTOCOL, ORIGINAL.....	230
SEMI –STRUCTURED INTERVIEW PROTOCOL, REVISED.....	232

SEMI-STRUCTURED INTERVIEW PROTOCOL, ORIGINAL

Date and Time of Interview: _____

Participant ID: _____

Script:

Thank you for agreeing to meet with me today. I have provided you with a copy of your results from the repeated measures and will be asking you to share your thoughts and insights about your results. If at any time you do not understand a question or I am not clear, please let me know so I can repeat or reframe the question. I also want to remind you that I will be audio recording our meeting today. Please know that the information you share with me today will be confidential and no personal identifying information will be linked with our conversation. I also ask that if you do speak about a client that you use the client's initials and not the client's name. Do you have any questions for me at this time? Are you ready to begin?

1. As you look at your graph, what are your initial reactions to your results?
 - a. Probe for any expectations
 - b. Probe for any surprises
2. As you reflect on your experiences across the past three to four weeks, is there anything that stands out for you that might be related to or have impacted your results?
 - a. Probe about schedule
 - b. Probe about school
 - c. Probe about supervision
 - d. Probe about relationship(s)
 - e. Probe for any new stressors
 - f. Probe for self-care and coping strategies
 - g. Probe about clients
3. How would you define trauma?
 - a. Probe if any clients they have seen over the last few weeks fit this definition.
4. Is there anything else you would like to share with me today?

Thank you so much for sharing this information with me. From here, I will be transcribing our interview and putting together a narrative description of what you have shared. I will be sending you a copy of this once it is completed and will ask you to verify the accuracy to ensure I have captured your information completely. Thank you again for speaking with me today.

SEMI –STRUCTURED INTERVIEW PROTOCOL, REVISED

Date and Time of Interview: _____

Participant ID: _____

Script:

Thank you for agreeing to meet with me today. I have provided you with a copy of your results from surveys and will be asking you to share your thoughts and insights about your results. If at any time you do not understand a question or I am unclear, please let me know so I can repeat or reframe the question. I also want to remind you I will be audio recording our meeting today. Please know that the information you share with me is confidential and no personal identifying information will be linked with our conversation. I also ask that if you do speak about a client that you use the client's initials and not the client's name. Do you have any questions for me at this time? Are you ready to begin?

5. Share with me what a typical day at your practicum or internship site was like.
6. I am going to ask you to look at your results that I provided to you. As you look at your results, what are your initial reactions to your results?
 - a. Probe for any expectations
 - b. Probe for any surprises
 - c. Probe for how they view the surveys as reflective of their experiences in practicum or internship.
7. As you reflect on your experiences across this semester, is there anything that stands out for you that might be related to or have impacted your results?
 - a. Probe about schedule
 - b. Probe about school
 - c. Probe about supervision
 - d. Probe about relationship(s)
 - e. Probe for any new stressors
 - f. Probe for self-care and coping strategies
 - g. Probe about clients

8. When you think about the clients you worked with during practicum or internship, is there one that sticks out for you the most?
 - a. Probe for what about the selected client sticks out
 - b. Probe for information about client's story
 - c. Probe how similar or dissimilar client is to the participant interviewee
9. What is it like for you to share this client's story and information with me right now?
 - a. Probe for any thoughts
 - b. Probe for any emotions/feelings
 - c. Probe for any physical sensations
10. How would you define trauma?
11. Have you provided counseling to clients who have experienced trauma, as you have defined it? (If participant has already talked about a client with a history of trauma in above questions, move to question 9. If participant says no, move to last question.)
 - a. Probe for what types of trauma the client(s) shared
12. When you heard about your client's traumatic experience how did you respond or react during the session?
 - a. Probe for thoughts
 - b. Probe for feelings/emotions
 - c. Probe for physical sensations/reactions
13. How did you cope with hear about your client's trauma?
 - a. Probe for when participant used coping skills (during session and after session)
14. Is there anything else you would like to share with me today?

Thank you so much for sharing this information with me. I will be email you the \$10 e-gift card to (insert choice for e-gift card) at the following email address (verify participant's email address). Thank you again for speaking with me today.

APPENDIX D
PARTICIPANT RECRUITMENT

	Page
INITIAL PARTICIPANT RECRUITMENT EMAIL.....	235
PARTICIPANT RECRUITMENT FOR INTERVIEWS.....	237
PARTICIPANT COMMUNICATION REGARDING INTERVIEWS.....	238

INITIAL PARTICIPANT RECRUITMENT EMAIL

Dear Counseling Student,

Today, I am writing to invite you to help future counselors in training on their journey to becoming a counselor. I am a doctoral student at The University of North Carolina at Greensboro. As a participant in my study, *A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training*, you will be asked share information about your experiences as a counselor in training during your practicum or internship course by answering survey questions. The purpose of this study is to better understand the initial experiences of counselors in training as they begin seeing clients, especially those seeing clients who have a history of trauma.

Please know that the information you share is voluntary and will remain confidential.

If you are at least 20 years old and a master's level counseling graduate student currently enrolled in a practicum or internship course, you can help by:

1. Taking 20-30 minutes of your time to complete the initial survey.
2. Clicking on the following link to complete the survey (INSERT QUALTRICS LINK)

In exchange for your time and help during this study, you will receive:

1. A list of wellness resources for staying healthy on your journey as a counselor.
2. The knowledge that you are helping future counselors in training, counselors in the field, counselor educators, and supervisors.
3. The first 100 participants to complete the survey will receive a \$5 e-gift card to your choice of Amazon.com, Starbucks, Target, or Panera.
4. If you complete all surveys and are willing to volunteer to complete an interview, you will receive a copy of your survey results.

A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training will be conducted in two phases. The first phase will ask participants to complete an initial survey. The second phase will invite participants who volunteer and whom are selected to participate in a semi-structured interview facilitated by me that is anticipated to take a minimum of 45 minutes to a maximum of 90 minutes. The interview will focus on your initial experiences of working with clients and explore your survey results.

Please note this study is NOT about critiquing the practicum or internship site. Instead, the study is designed to gather information specifically related to the experience of master's level counselors in training while working with clients in practicum or internship.

PLEASE CLICK ON THIS LINK TO GO TO THE SURVEY: (INSERT QUALTRICS LINK)

The study is approved by the Institutional Review Board at The University of North Carolina at Greensboro. If you have questions you may contact the primary investigator/researcher, Tamarine Foreman at tmforema@uncg.edu.

Sincerely, Tamarine M. Foreman, MEd, NCC, LPCC-s (Ohio)
Principal Investigator and Doctoral Candidate
The University of North Carolina at Greensboro

Approved IRB
11/5/14

PARTICIPANT RECRUITMENT FOR INTERVIEWS

Dear Participant,

Thank you for agreeing to participate in the interview for the study, *A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training*.

I would like to invite you to participate in a semi-structured interview with me. The interview focuses on your experiences as a counselor in training and is expected to take approximately 45 to 60 minutes. During the interview, we will take time to review your results from the repeated surveys you completed during the first phase of the study.

You may select the day and time of the interview and the method (telephone, Google hangout, or Skype). In exchange for your time and as a token of appreciation, you will receive a \$10 gift card to your choice of Amazon.com, Starbucks, Target, or Panera.

The study has been approved by the Institutional Review Board at The University of North Carolina at Greensboro. If you have questions you may contact the primary investigator/researcher, Tamarine Foreman at tmforema@uncg.edu.

Click this link to read the Informed Consent and make your gift card selection: [INSERT QUALTRICS LINK TO INFORMED CONSENT]

Thank you for your time.

Sincerely,
Tamarine M. Foreman, MEd, NCC, LPCC-s (Ohio)
Principal Investigator and Doctoral Student
The University of North Carolina at Greensboro

Approved IRB

11/5/14

PARTICIPANT COMMUNICATION REGARDING INTERVIEWS

Follow Up Email to Schedule Interview

Dear Participant,

Thank you for agreeing to participate in the interview for the study, *A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training*. As I mentioned, I am a doctoral student at The University of North Carolina at Greensboro.

The purpose of this study is to better understand your initial experiences as a counselor in training as you begin seeing clients, especially those clients who have a history of trauma. It is also to explore any change or lack of change that occurred on the surveys you completed.

Based on the information you provided, can you meet on [INSERT DAY, TIME, DATE]? {If speaking via phone: “What phone number should I call to reach you on this day?”}

Once you confirm the date and time for our interview, I will email you 24 to 48 hours in advance of our scheduled meeting time and provide you with a copy of your survey results. I look forward to speaking with you.

The study has been approved by the Institutional Review Board at The University of North Carolina at Greensboro. If you have questions you may contact me at tmforema@uncg.edu or call (336) 334-3423.

Thank you for your time.

Sincerely,
Tamarine M. Foreman, MEd, NCC, LPCC-s (Ohio)
Principal Investigator and Doctoral Student
The University of North Carolina at Greensboro

Confirmation Email sent 24-48 hours prior to Interview

Dear Participant,

Thank you for agreeing to participate in the interview for the study, *A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training*. As I mentioned, I am a doctoral student at The University of North Carolina at Greensboro.

I look forward to speaking with you on [INSERT DAY/TIME] via [INSERT METHOD: PHONE, GOOGLE HANGOUT OR SKYPE].

The purpose of this study is to better understand your initial experiences as a counselor in training as you begin seeing clients, especially those clients who have a history of trauma. It is also to explore any change or lack of change that occurred on the surveys you completed.

I have attached a copy of your results from the repeated surveys. Please take a moment to review the results prior to our interview, as we will be to discussing your reactions during the interview.

Thank you kindly for your time. I look forward to speaking with you.

Sincerely,
Tamarine M. Foreman, MEd, NCC, LPCC-s (Ohio)
Principal Investigator and Doctoral Student
The University of North Carolina at Greensboro

APPENDIX E

WELLNESS RESOURCES

Wellness Resources

American Counseling Association has dedicated space on their website that contains wellness information: <http://www.counseling.org/knowledge-center/counselor-wellness>

The Substance Abuse and Mental Health Association provides a holistic guide to whole-person wellness at the following website:

<http://www.promoteacceptance.samhsa.gov/10by10/dimensions.aspx>

For additional reading, please check out these books:

Davis, M., Eshelman, E. R., & McKay, M. (2008). *The relaxation and stress reduction workbook (6th edition)*. Oakland, CA: New Harbinger Publications.

Hill, M. (2004). *Diary of a country therapist*. New York: Hayworth Press.

Pearlman, L. A. & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton & Company.

Pearlman, L.A. & Saakvitne, K.W. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton & Company.

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York: W.W. Norton & Company.

Skovholt, T. M. (2001). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*. Boston, MA: Allyn & Bacon.

Stamm, B. H. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators (2nd edition)*. Baltimore, MD: Sidran Press.

For additional reading, please check out these articles:

Lawson, G. (2007). Counselor wellness and impairment: A national survey. *Journal of Humanistic Counseling, Education and Development*, 46, 20–34.

Lawson, G., & Myers, J. E. (2011). Wellness, professional quality of life, and career-sustaining behaviors: What keeps us well? *Journal of Counseling & Development*, 89, 163–171.

- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149. doi: 10.1007/BF00975140
- Myers, J. E. (1992). Wellness, prevention, development: The cornerstone of the profession. *Journal of Counseling & Development, 71*, 136.
- Swarbrick, M. (2006). A wellness approach. *Psychiatric Rehabilitation Journal, 29*(4), 3311-3314.
- Trippany, R. L., Kress, V. E. White, & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development, 82*, 31-37.
- Warren, J., Morgan, M., Morris, L. B., & Morris, T. M. (2010). Breathing words slowly: Creative writing and counselor self-care—The writing workout. *Journal of Creativity in Mental Health, 5*, 109–124. doi:10.1080/15401383.2010.485074

APPENDIX F

IRB APPROVAL LETTER



THE UNIVERSITY of NORTH CAROLINA
GREENSBORO

OFFICE OF RESEARCH INTEGRITY
2718 Beverly Cooper Moore and Irene Mitchell Moore
Humanities and Research Administration Bldg.
PO Box 26170
Greensboro, NC 27402-6170
336.256.0253
Web site: www.uncg.edu/orc
Federalwide Assurance (FWA) #216

To: Tamarine Foreman
Counsel and Ed Development

From: UNCG IRB

A handwritten signature in black ink, appearing to read "Laurie Wedeno".

Authorized signature on behalf of IRB

Approval Date: 9/22/2014

Expiration Date of Approval: 9/21/2015

RE: Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)

Submission Type: Initial

Expedited Category: 7.Surveys/interviews/focus groups,6.Voice/image research recordings

Study #: 14-0327

Study Title: A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training

This submission has been approved by the IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

Study Description:

The proposed study will examine how master's level counseling graduate students are impacted when they begin seeing clients, especially those clients who may have experienced trauma. The study will be carried out in two phases with the first phase asking participants to complete an initial survey. The initial survey will also ask participants to volunteer to continue the study by taking an additional four surveys. The second phase will ask 4-8 selected participants who complete all surveys and who volunteer, to complete one semi-structured interview. The proposed study will provide information on the experiences of counselors in training that contribute to vicarious traumatization and posttraumatic growth.

Regulatory and other findings:

- This research meets criteria for waiver of a signed consent form according to 45 CFR 46.117(c)(2).

Investigator's Responsibilities

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Signed letters, along with stamped copies of consent forms and other recruitment materials will be scanned to you in a separate email. **Stamped consent forms must be used unless the IRB has given you approval to waive this requirement.** Please notify the ORI office immediately if you have an issue with the stamped consents forms.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented (use the modification application available at <http://integrity.uncg.edu/institutional-review-board/>). Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB using the "Unanticipated Problem-Adverse Event Form" at the same website.

Please be aware that valid human subjects training and signed statements of confidentiality for all members of research team need to be kept on file with the lead investigator. Please note that you will also need to remain in compliance with the university "Access To and Retention of Research Data" Policy which can be found http://policy.uncg.edu/research_data/.

CC:
Kelly Wester, Counsel and Ed Development

APPENDIX G

PILOT STUDY

	Page
PILOT STUDY: INFORMED CONSENT	244
PILOT STUDY RECRUITMENT EMAIL.....	247
PARTICIPANT REMINDER EMAILS.....	249
PILOT STUDY	251

PILOT STUDY: INFORMED CONSENT

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT TO ACT AS A HUMAN PARTICIPANT

Project Title: Phase 1: *A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training*

Principal Investigator and Faculty Advisor: Tamarine M. Foreman, MSED, NCC, Principal Investigator;
Kelly Wester, PhD, Faculty Advisor

What are some general things you should know about research studies?

You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or the University of North Carolina at Greensboro.

Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study. You may print this consent form for your records by printing this form before you move forward. If you have any questions about this study at any time, you should ask the researchers named in this consent form. Their contact information is below.

What is the study about?

This is a research project. Your participation is voluntary. The purpose of this study is to better understand the initial experiences of counselors in training as they begin seeing clients, especially those seeing clients who have a history of trauma.

Why are you asking me?

You are being asked to participate because you are 1) at least 20 years old; 2) attending a master's level graduate counseling program that has received or applied for CACREP accreditation; and 3) you are currently enrolled in a practicum or internship.

What will you ask me to do if I agree to be in the study?

The study will ask you to complete a survey. It is estimated to take approximately 10-20 minutes to complete the initial survey. You have the opportunity to voluntarily continue participating by agreeing to take up to four shorter additional surveys estimated to take approximately 10-20 minutes each. It is possible, though unlikely, that questions on the surveys may cause minimal emotional stress.

If you have questions or concerns about your level of participation, please contact the primary investigator, Tamarine Foreman by phone (336) 334-3423, or email tmforema@uncg.edu.

What are the risks to me?

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. The minimal risks may include emotional reactions to questions on the surveys and are not expected to require medical or psychological treatment. Please know you have the option not to respond to any questions that cause you to feel uncomfortable or emotionally distressed.

If you feel any emotional distress, you are encouraged to seek counseling from a qualified professional.

The following online database of counselors can assist you in locating a qualified professional:

<http://www.nbcc.org/CounselorFind>.

UNCG IRB
Approved Consent Form
Valid from:
9/22/14 to 9/21/15

If you have questions, want more information or have suggestions, please contact Tamarine Foreman at (336) 334-3423 or email at tmforema@uncg.edu or faculty advisor Kelly Wester, PhD at klwester@uncg.edu.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

Are there any benefits to society as a result of me taking part in this research?

Your participation may assist counselors in training, counselors, counselor educators, and supervisors to address the impact of vicarious traumatization and post-traumatic growth. It is hoped the research will lead to a better understanding of how to better train and support counselors in training.

Are there any benefits to me for taking part in this research study?

There are no direct benefits to participants in this study.

Will I get paid for being in the study? Will it cost me anything?

There are no costs to you nor direct payments made for participating in this study. However, if you participate in this initial survey in addition to volunteering to complete up to 4 additional surveys you will be eligible to be entered into a raffle for 1 of 2 gift cards valued at \$5 or 1 of 9 gift cards valued at \$10 to their choice of Amazon.com, Starbucks, Target, or Panera. The first five participants will also be eligible to receive a list of wellness resources and a copy of their results after completing three surveys.

How will you keep my information confidential?

The information you share will be kept confidential. Confidential data collection procedures have been put into place. The Qualtrics online web tool meets the strictest confidentiality standards and is in full compliance with HIPPA. Toward the end of the study and once data collection has been completed, all identifying information, such as email addresses, that were collected for distribution purposes will be removed from all databases and replaced with a randomly created id number.

All information obtained from surveys will be stored in password protected files and password protected folders on a password protected computer. Any identifying information will be maintained separate from response data in a password protected file on a password protected computer. When the password protected computer is not in use, it will be stored behind a locked door. All information obtained in this study is strictly confidential unless disclosure is required by law.

Please also note that absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing.

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

What about new information/changes in the study?

If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Voluntary Consent by Participant:

By signing this consent form you are agreeing that you read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By signing this form, you are agreeing that you are 18 years of age or older and are agreeing to participate.

UNCG IRB
Approved Consent Form
Valid from:

9/22/14 to 9/21/15

Signature: _____ Date: _____

Online Electronic Consent:

Voluntary Consent by Participant:

By checking the box below on this consent form you are agreeing that you have read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By checking the box below on this form, you are agreeing that you are 18 years of age or older and are agreeing to participate.

- ☐ Yes, I have read and understood this consent form and voluntarily consent to participate in this study.
- ☐ No, I do not wish to participate in this study.

UNCG IRB
Approved Consent Form
Valid from:

9/22/14 to 9/21/15

PILOT STUDY RECRUITMENT EMAIL

Dear Counseling Student,

Today, I am writing to invite you to help future counselors in training on their journey to becoming a counselor. I am a doctoral student at The University of North Carolina at Greensboro. As a participant in my study, A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training, you will be asked to share information about your experiences as a counselor in training during your practicum or internship course by answering survey questions. The purpose of this study is to better understand the initial experiences of counselors in training as they begin seeing clients, especially those seeing clients who have a history of trauma.

Please know that the information you share is voluntary and will remain confidential.

If you are at least 20 years old and a master's level counseling graduate student currently enrolled in a practicum or internship course, you can help by:

1. Taking 10-15 minutes of your time to complete the initial survey.
2. Clicking on the following link to complete the survey [Insert Qualtrics Anonymous Link]

In exchange for your time and help during this study, you will receive:

1. A list of wellness resources for staying healthy on your journey as a counselor.
2. The knowledge that you are helping future counselors in training, counselors in the field, counselor educators, and supervisors.
3. An opportunity to continue helping by taking 2 additional surveys. If you complete all surveys you will receive a copy of your survey results.

Please note this study is NOT about critiquing the practicum or internship site. Instead, the study is designed to gather information specifically related to the experience of master's level counselors in training while working with clients in practicum or internship.

PLEASE CLICK ON THIS LINK TO GO TO THE SURVEY: [Insert Qualtrics Anonymous Link]

The study is approved by the Institutional Review Board at The University of North Carolina at Greensboro. If you have questions you may contact the primary investigator/researcher, Tamarine Foreman at tmforema@uncg.edu.

Thank you for your time and best wishes on your continued journey.

Sincerely,
Tamarine M. Foreman, MEd, NCC, LPCC-s (Ohio)
Principal Investigator and Doctoral Student
The University of North Carolina at Greensboro

PARTICIPANT REMINDER EMAILS

A. Email to Participant who agrees to continue with the study.

Dear Participant,

Thank you for completing the initial survey and agreeing to continue helping with the study, *A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training*. The purpose of this study is to better understand the initial experiences of counselors in training as they begin seeing clients, especially those seeing clients who have a history of trauma. As I mentioned, I am a doctoral student at The University of North Carolina at Greensboro.

You will receive an email next week on Tuesday morning containing a link to the next survey. When you receive the link, I ask that you complete the survey within 12 hours of receiving the email.

Again, thank you for your continued assistance.

Sincerely,

Tamarine M. Foreman, MEd, NCC, LPCC-s (Ohio)
Principal Investigator and Doctoral Student
The University of North Carolina at Greensboro

B. Email to Participant who agrees to continue with the study containing Qualtrics link to Survey 2 and 3.

Dear Participant,

Thank you for completing the initial survey and agreeing to continue helping with the study, *A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training*. The purpose of this study is to better understand the initial experiences of counselors in training as they begin seeing clients, especially those seeing clients who have a history of trauma. As I mentioned, I am a doctoral student at The University of North Carolina at Greensboro.

Here is the link to the next survey: [INSERT QUALTRICS LINK].

Please complete the survey within 12 hours of receiving this email.

Sincerely,
Tamarine M. Foreman, MEd, NCC, LPCC-s (Ohio)
Principal Investigator and Doctoral Student
The University of North Carolina at Greensboro

C. Reminder Email to Participant who agrees to continue with the study to complete Survey 2 and 3.

Dear Participant,

Thank you for completing the initial survey and agreeing to continue helping with the study, *A Mixed Methods Evaluation of Vicarious Traumatization and Posttraumatic Growth among Counselors in Training*. The purpose of this study is to better understand the initial experiences of counselors in training as they begin seeing clients, especially those seeing clients who have a history of trauma. As I mentioned, I am a doctoral student at The University of North Carolina at Greensboro.

I sent a previous email to you on [Tuesday or Friday] morning asking you to complete the next survey. It is possible the email went to your spam folder instead of to your inbox.

Please take a moment as soon as possible to complete the next survey.
Here is the link: [INSERT QUALTRICS LINK]

Again, thank you for your continued assistance.

Sincerely,
Tamarine M. Foreman, MEd, NCC, LPCC-s (Ohio)
Principal Investigator and Doctoral Student
The University of North Carolina at Greensboro

PILOT STUDY

Introduction

After receiving IRB approval, the researcher implemented a pilot study. The purpose of the pilot study was to evaluate attrition, explore any observed changes in scores on the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010) observed after administrations at baseline and two subsequent time points within a two week timeframe, and refine study procedures.

Research Questions and Hypotheses

The following research questions are exploratory in nature and will be examined in the pilot study.

Research Question 1: What level of vicarious traumatization and/or posttraumatic growth as measured by the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010) do counselors in training exhibit?

Hypothesis 1a: Although this question is exploratory in nature, it is assumed that counselors in training will exhibit some vicarious traumatization and perhaps posttraumatic growth. It is unknown what levels of vicarious traumatization and posttraumatic growth will be exhibited.

Research Question 2: Do the observed scores on the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010) reflect change after three administrations for counselors in training?

Research Question 3: What is the attrition rate for participants in the pilot study?

Research Question 4: What improvements do the participants in the pilot study suggest?

Sample and Participant Selection

A sampling pool of five participants, who are master's level counselors in training and currently completing a counseling internship, were recruited from one supervision group in a full time master's level counseling program in the southeast. The counseling program is CACREP accredited and requires all students to complete a 100-hr advanced clinical practicum and two 300-hour counseling internships. The participants will be master's level graduate students in their second year of a two-year fulltime program who have completed approximately thirty credit hours and in one of the following program tracks: Clinical Mental Health Counseling, School Counseling, Couple and Family Counseling, or College Counseling/Student Development in Higher Education.

Instrumentation

Vicarious Traumatization. The Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) will be used to measure vicarious traumatization. The TABS (Pearlman, 2003) measures cognitive disruptions occurring as a result of vicarious traumatization as conceptualized by the CSDT. According to CSDT, the more trauma a person is exposed to the more disruption to the person's basic beliefs and assumptions about their self, others, and the world. The disruption can lead to changes in how a person views their needs for safety, trust, esteem, intimacy, and control. The TABS (Pearlman, 2003) is the updated version of the former Traumatic Stress Institute Belief Scale-Revision L (Pearlman, 1996), revised to improve readability.

The TABS contains 84 questions written at a 3rd grade reading level. Respondents answer on a 6-point Likert-type agreement scale (1=strongly disagree to 6=strongly agree) and can be completed in 15 to 20 minutes. The total score on the TABS indicates the amount of cognitive disruption to beliefs about the self, others, and world. The total score obtained on the TABS (Pearlman, 2003) ranges from the lowest score of 84 to highest score of 504. In order to interpret the TABS (Pearlman, 2003) the raw total score is transformed to a standardized T score to with a mean of 50 and a standard deviation of 10. Scores range from very little disruption to substantial disruption with higher scores indicating more disruption.

The TABS yields scores for each of the 10 subscales and a total overall score. For the purposes of this study, only the total overall score will be utilized. The subscales provide information related to a counselor's disruption of beliefs related to the psychological needs of safety, trust, esteem, intimacy, and control. The subscale items are separated into perceptions of self and other. Example items include: "I feel threatened by others" (self-safety); "I never think anyone is safe from danger" (other safety); "I often doubt myself" (self-trust); "Trusting people is not smart" (other-trust); "I'm not worth much" (self-esteem); People are no good" (other-esteem); "I hate to be alone" (self-intimacy); "I feel cut off from people" (other-intimacy); "I have problems with self-control" (self-control); and "I can't do good work unless I am the leader" (other-control). Internal consistencies for the subscales are as follows: self-safety (.83), other-safety (.72), self-trust (.74), other-trust (.84), self-esteem (.83), other-esteem (.82), self-intimacy (.67), other-intimacy (.87), self-control (.73), and other-control (.75). The reported Cronbach's

alpha for overall TABS is .96 (Pearlman, 2003). Williams, Helm, and Clemens (2012) utilized the full scale of the TABS to evaluate vicarious traumatization in clinical mental health counselors working in community mental health centers. The authors reported an overall total score Cronbach alpha reliability estimate of .95 (Williams et al., 2012).

Pearlman (2003) reported interscale correlations, factor structure, and correlations to similar instruments to support construct validity. Pearlman (2003) reported subscales to be highly intercorrelated with one another and that each subscale was more highly correlated to the total TABS score than to any other subscale. Varra, Pearlman, Brock, and Hodgson (2008) investigated the factor structure of the TABS (Pearlman, 2003). The researchers described a three-factor solution inclusive of self, other, and safety (world), which is consistent with CSDT and the subscales of the TABS (Varra, Pearlman, Brock, & Hodgson, 2008). Pearlman (2003) also examined the correlations of TABS scores with scores on the Trauma Symptom Inventory (TSI; Briere, 1995). Pearlman (2003) described the total scores of the TABS to be highly correlated with the TSI subscales of depression, dissociation behavior, and impaired self-reference which reflect an internal process of experiences.

Criterion related validity of the TABS has been supported by multiple studies that have assessed vicarious traumatization among persons who have experienced trauma directly (Dutton, Burghardt, Perrin, Chrestman, & Halle, 1994; Goodman & Dutton, 1996; Mas, 1992) and indirectly (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). These researchers reported that persons, who have a history of trauma, and therapists

with greater exposure to client trauma, exhibited higher scores on the TABS than those persons without a trauma history or less exposure to client trauma.

Posttraumatic Growth. The Posttraumatic Growth Inventory-Short Form (PTGI-SF; Cann, et al., 2010) assesses the extent to which individuals believe they have positively changed after exposure to a traumatic event. The PTGI-SF is an abbreviated form of the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996). Cann and colleagues (2010) based the PTGI-SF on the longer PTGI and described the shorter form as psychometrically sound for use as a brief assessment tool of posttraumatic growth. Although the PTGI was originally designed to measure growth after direct experience to trauma, the measure has been utilized to measure indirect exposure to trauma in counselors (e.g. Brockhouse et al., 2011; Linley & Joseph, 2007). Brockhouse and colleagues (2011) reported a Cronbach alpha of .95 for internal consistency when using the PTGI. It is important to note that Tedeschi and Calhoun (1996) reported the PTGI did not correlate with social desirability. The PTGI-SF has not yet been utilized to assess posttraumatic growth in counselors.

The PTGI-SF consists of 10 questions, which asks respondents to answer on 6-point Likert Scale (0=I did not experience this change; I experienced this change to a 1=very small degree, 2=small degree, 3=moderate degree, 4=degree, 5=very great degree). The PTGI-SF evaluates growth along five dimensions (relating to others, new possibilities, personal strength, spiritual change, and appreciation of life). Example items include: “I have a greater sense of closeness with others” (relating to others); “I established a new path for my life” (new possibilities); “I discovered that I am stronger

than I thought I was” (personal strength); “I have a better understanding of spiritual matters” (spiritual change); and “I have a greater appreciation for the value of my own life” (appreciation of life). Despite the PTGI-SF having five underlying factors, a total score is used to represent the amount of posttraumatic growth with higher scores indicating more growth (Cann et al., 2010). For the purposes of this study, only the total score will be utilized.

Studies have been conducted to explore and validate the internal reliability of the PTGI-SF (Cann et al., 2010). Calhoun, Tedeschi, Fulmer, and Harlan (2000) examined posttraumatic growth in 32 parents who had lost a child. The researchers reported a coefficient alpha internal reliability estimate of .84 (Calhoun, Tedeschi, Fulmer, & Harlan, 2000). Another study by Cobb, Tedeschi, Calhoun, and Cann (2006) reported a coefficient alpha internal reliability estimate of .90 when they examined posttraumatic growth in 60 women seeking shelter from intimate partner violence. Cann and colleagues (2010) reported a coefficient alpha internal reliability estimate of .93 when researching posttraumatic growth among cancer patients (n=72). These researchers also reported a coefficient alpha internal reliability estimate of .90 when evaluating posttraumatic growth among 85 college students (Cann et al., 2010).

Validity of the PTGI has been explored through confirmatory factor and correlational analyses. The confirmatory factor analysis conducted by Cann and colleagues (2010) supported a five factor structure of the PTGI-SF which is identical to the five factor structure of the PTGI that was supported by the confirmatory factor analysis completed by Taku, Cann, Calhoun, and Tedeschi (2008). The five factor

structure includes five dimensions of growth in the areas of relating to others, new possibilities, personal strength, spiritual change, and appreciation of life. In a study conducted by Calhoun, Cann, Tedeschi, and McMillan (2000), a significant association between posttraumatic growth and the degree of self-reported rumination soon after an event ($r = .57, p < .001$) was reported, indicating that the more a person ruminates and tries to make meaning after a traumatic event, the more likely that higher levels of posttraumatic growth would be observed. The results reported by Calhoun and colleagues (2000) are similar to the results in an earlier study by Tedeschi and Calhoun (1996) where people who reported a experiencing serve trauma, as measured by the Traumatic Stress Schedule (Norris, 1980), also reported higher levels of posttraumatic growth (as measured by the PTGI). These results are inline with the theoretical conceptualization of posttraumatic growth which proposes that people who think more about a traumatic event and the event's significance and meaning are more likely to experience posttraumatic growth (Tedeschi & Calhoun, 1995; Tennen & Affleck, 1998).

Procedures

After receiving IRB approval to proceed with the study, the researcher emailed one internship supervisor from CED at The University of North Carolina at Greensboro and asked the supervisor to forward an email to counselors in training from their supervision group. The email forwarded to the counselors in training invited them to participate in the pilot study. Perspective participants were advised that all of their information would be kept confidential and that supervisors and faculty would not have access to their results nor be made aware of who participated in the pilot study.

The forwarded email asked the counselors in training to click on a link to the Qualtrics online survey, which contained the informed consent, surveys, and provided the option to continue in the study. The first section of the online survey asked participants to read the informed consent, select they have read and understood the informed consent, and agree to participate. Once a participant agreed to participate, they were directed to the second section of the survey containing the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010). The presentation order of the standardized instruments was alternated across surveys to help decrease the possibility of order effects. The instructions for the TABS (Pearlman, 2003) on all three surveys instructed participants to “As people differ from one another in many ways, there are no right or wrong answers. Please click the circle next to each item that you feel most clearly matches your own beliefs about yourself and your world at the current moment.” The instructions for the PTGI-SF (Cann et al., 2010) on the baseline survey instructed participants to “Indicate, by clicking a circle next to each of the statements below, the degree to which the stated change occurred in your life as a result of beginning to work with clients.” Subsequent presentations of the PTGI-SF (Cann et al., 2010) instructed participants to “Indicate, by clicking a circle next to each of the statements below, the degree to which the stated change occurred in your life since completing the previous survey.” Once participants completed the second section, they were directed to the third section, which asked participants to voluntarily provide their email address in order to receive the link to the second and third survey and be eligible for incentives at the end of the pilot study.

Participants were asked to complete the initial (baseline) survey within 24 hours of receiving the email.

Once a participant completed the initial survey, they received an email response thanking them and advising they would receive a second email the following week on Wednesday. On Wednesday morning, participants were sent a second email asking them to click on a link to complete the second Qualtrics online survey within 12 hours of receiving the email. After completing the Wednesday survey, the participant received an email response thanking them for completing the survey and advising the third and final email would be sent to them on Friday. On Friday morning, the researcher emailed participants directing them to the Qualtrics link to complete the final survey within 12 hours of receiving the email. Participants who did not complete either the Wednesday or Friday survey within 24 hours received a reminder email asking them to complete the survey as soon as possible.

The Wednesday and Friday surveys contained the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010), which were presented in alternating order to decrease the potential of order effects. The final survey sent on Friday contained three open-ended questions inquiring about the approximate length of time to take the surveys, suggestions for improvement, and feed back on incentives. At the end of the pilot study, all participants who completed all parts of the survey at all three time points were emailed a list of wellness resources and their written and graphical report containing their individualized survey results.

All data has been kept on a password protected computer in password protected files. Access to the data was limited only to the primary researcher and faculty advisor. Pilot study participants were assigned an identification number to be used for data analysis. The researcher did not collect participant names and only utilized participant email addresses for repeated administration of measures and for distribution of incentives. All identifying information was maintained in a password protected file kept separate from data results. Any discussion of the results from the pilot study was provided in aggregate form and not linked to any individual participant. Participants also had the right to drop out of the pilot study at any time without any threat of harm.

Data Analysis and Results

Descriptive statistics were computed to analyze the results and answer the research questions. The analyzed information included the mean, minimum and maximum values, and standard deviation. Inferential statistics were not computed because the small sample size was inadequate to demonstrate moderate power and statistical significance. The descriptive statistics were utilized to examine the amount of vicarious traumatization and posttraumatic growth counselors in training exhibited as measured by the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010). Descriptive statistics were also implemented to assess the observed change in scores on the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010) from baseline and across two additional administrations. The final research question was analyzed for common themes and suggestions on how to improve and refine study procedures.

A total of five counselors in training who were completing their internship were invited to participate in the pilot study through the email forwarded to them from their internship supervisor. Of the five counselors in training invited, two counselors in training completed the baseline survey. A response rate of 40% was calculated for the baseline survey. An attrition rate of 50% was observed when moving from baseline to subsequent surveys as one of the two counselors in training agreed to and completed the subsequent surveys. The average time to complete the surveys was nine minutes and twenty seconds and all surveys were completed within 12 hours of receiving the email request to complete the survey.

Research Question 1: Research question one addressed the question of whether or not counselors in training would exhibit vicarious traumatization as measured by the TABS (Pearlman, 2003) and posttraumatic growth as measured by the PTGI-SF (Cann et al., 2010). The hypothesis that some level of vicarious traumatization and posttraumatic growth would be observed for counselors in training participating in this study was supported.

Vicarious Traumatization. The participants in the pilot study varied in their levels of vicarious traumatization at baseline. Based on the total raw scores at baseline (202, 149), both participants scored within the range of total scores similar to the study conducted by Williams and colleagues (2012), who reported total raw scores on the TABS (Pearlman, 2003) ranged from 113 to 327 among 131 community mental health counselors. For this pilot study, the researcher computed T scores to compare the participants' baseline scores to one another. However, it is important to note that these

standardized scores were based on a small and non-representative sample. One participant demonstrated a low average score (T score = 43) and the second participant demonstrated a high average level (T score = 57) of vicarious traumatization. Pearlman (2003) reported trauma therapists (N = 266) had a mean T Score of 44. This indicates the second participant was exhibiting levels of vicarious traumatization higher than trauma therapists and is potentially experiencing notable disruption in how the counselor in training perceives their self as competent, others as trustworthy, and the world as safe. In addition, the second participant did not continue with the study. The experiencing of higher than average levels of vicarious traumatization indicates the potential for counselors in training to suffer from symptoms of vicarious traumatization, which could inhibit continued participation. This also indicates that participants with average to lower average levels of vicarious traumatization may be more willing to continue. The results are provided in Table 3.

Posttraumatic Growth. The initial baseline survey asked participating counselors in training to respond to how their lives have changed as a result of beginning to see clients. The total raw scores on the PTGI-SF (Cann et al., 2010) range from zero to 50. The final score for the PTGI-SF (Cann et al., 2010) are a computed average. Based on the total score and averaged final score, participants in the pilot study demonstrated a moderate degree of posttraumatic growth as a result of seeing clients. An inference can be made that the counselors in training experienced a moderate degree of change in posttraumatic growth overall with moderate improvement in the areas of relating to others, openness to new possibilities, personal strength, spiritual change, and appreciation

of life. The results of this pilot study are similar to study results reported by Brockhouse and colleagues (2010) and Triplett, Tedeschi, Cann, Calhoun, and Reeve (2012) both of who utilized the PTGI (Tedeschi & Calhoun, 1996). Brockhouse and colleagues (2010) reported a small degree of posttraumatic growth among 118 therapists. In addition, Triplett and colleagues (2012) reported a small to moderate degree of posttraumatic growth among 333 participants who had experienced a traumatic event. The results for the pilot study are listed in Table 18.

Table 18

Baseline Results for the TABS and PTGI-SF

Instrument	Minimum	Maximum	Mean	Standard Deviation
TABS*	149	202	175.5	37.477
PTGI-SF*	28	29	28.5	0.707

Note: n = 2. * Raw total scores provided.

Research Question 2: The second research question was exploratory in nature with the intent of observing changes in scores on the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010) across the repeated administrations for counselors in training. In this pilot study, the surveys were administered a total of three times (Baseline, Time point 1, and Time point 2). Only one of the two counselors in training participated in these follow up surveys post baseline. The counselor in training who completed all surveys demonstrated change across each administration for both standardized instruments. The results of the repeated administered surveys are listed in Table 19 and Figures 2 and 3.

Vicarious Traumatization When evaluating the experience of vicarious traumatization, the participant's scores on the TABS (Pearlman, 2003) varied at each of the observations with the lowest score obtained at time point 1 (second administration) and the highest score obtained at the final time point.

Posttraumatic Growth. The participant scores on the PTGI-SF (Cann et al., 2010) demonstrated a small to moderate decline across all administrations reflecting a shift from moderate to small degree of posttraumatic growth as a result of seeing clients. The highest score and moderate amount of posttraumatic growth was observed at baseline (29) and the lowest score and very small degree of posttraumatic growth was observed at the final time point (7).

Table 19

Results for Repeated Administration of the TABS and PTGI-SF

Instrument	Baseline	Time point 1	Time point 2
TABS*	149	136	156
PTGI-SF*	29	12	7

Note: n = 1. *Raw total scores presented.

Figure 2. Repeated Administration of the TABS.

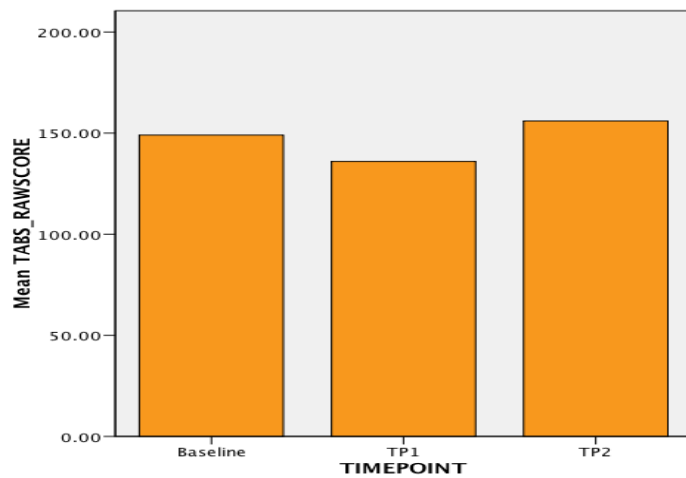
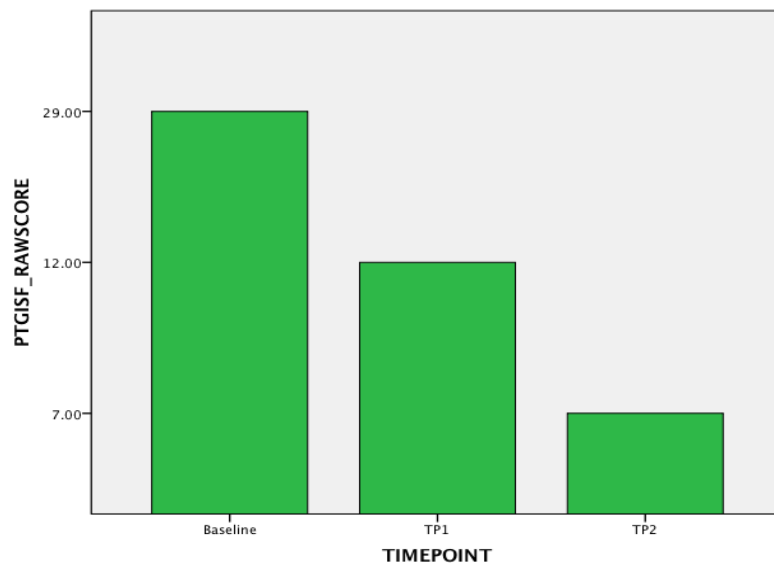


Figure 3. Repeated Administration of the PTGI-SF.



Research Question 3: The third research question addressed the concern of attrition. In the pilot study a response rate for the baseline survey of 40% was achieved and two of five participants completed the survey. However, the attrition rate for the repeated surveys was 50% as one of two participants who completed the baseline survey selected the option to continue participating.

Research Question 4: The final question solicited information on how to improve the survey. The participant who completed all three surveys expressed confusion about the questions being repeated in the subsequent surveys. In addition, the participant suggested they would not participate beyond three surveys and was uncertain as to what incentive would support additional participation.

Discussion

Based on the computation of descriptive statistics, the pilot study was able to demonstrate that counselors in training exhibit low to high average levels of vicarious traumatization and moderate amounts of posttraumatic growth as measured by the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010). In addition, change was observed across each repeated administration of both standardized instruments. Although this information is limited by the small number of participants and cannot be generalized to a larger population, the results indicate vicarious traumatization and posttraumatic growth as possible experiences for counselors in training as they begin to engage with clients within the proximal process of counseling.

Limitations

The small number of participants limited the results of the pilot study. The pilot study was also limited by a lack of demographic diversity among participants as the sampling pool was taken from the same supervision group at the same university graduate program. It is further limited by a lack of diversity when evaluating the results of the repeated measures because a single participant completed the survey and the participant demonstrated lower levels of vicarious traumatization than the participant who did not continue participating. Thus, there is potential for the full study to be limited as only participants who experienced average to low average levels of vicarious traumatization may participate in all time points of the study, while those experiencing higher than average levels of vicarious traumatization may not continue beyond baseline. Another limitation was inadvertently introduced to the pilot study due to the different instructions on subsequent administrations of the PTGI-SF (Cann et al., 2010). The instructions asked participants to respond to the amount of change since completing the previous survey. It is possible these instructions may have prohibited the participant from responding to their present momentary experience of posttraumatic growth. In addition, the instruction is different than those written by the researcher for the TABS (Pearlman, 2003), which remained the same for each administration and asked participants to answer based on their beliefs in the current moment. Another limitation stems from the lack of contextual and momentary information related to the participants' experiences and demographics that was not collected and may have contributed to the level of vicarious traumatization and posttraumatic growth.

Implications

Based on the results of the pilot study, changes for recruitment and methodology are implicated. The pilot study suggested that an additional number of participants be recruited to ensure the number of participants to complete specified data analyses be obtained. Therefore, the researcher has pursued and requested additional assistance from counselor education and supervision faculty at selected institutions that have received or applied for CACREP accreditation to ensure that the minimum number of participants for specified data analyses will be obtained. The researcher re-evaluated the methodology as the pilot study implicated that three administrations of the survey may be the maximum a participant is willing to complete. Therefore, changes to the initial methodology of baseline plus four follow up time points was altered to include only a baseline with two follow up administrations with the first time point (second administration) occurring on Tuesday instead of Wednesday.

In addition, the researcher will restructure the tiered incentive plan. In the full study, participants who complete the baseline survey and one shorter survey will now be eligible to be entered into the drawing for one of four \$5 e-gift cards, instead of the original requirement to complete baseline plus two shorter surveys and the potential to win one of two \$5 e-gift cards. In addition, participants in the full study who complete baseline plus two shorter surveys will be entered in a drawing for one of ten \$10 e-gift cards; an increase of one e-gift card for the drawing. Finally, the researcher will reword the instructions the PTGI-SF (Cann et al., 2010). The instructions for the pilot study asked participants to “Indicate, by clicking a circle next to each of the statements below,

the degree to which the stated change occurred in your life as a result of beginning to work with clients”, with subsequent instructions asking participants to indicate their answer based on any changes since completing the previous survey. For the full study, the instructions on the PTGI-SF (Cann et al., 2010) will ask participants on each survey to “Indicate, by clicking a circle next to each of the statements below, the degree to which the stated change occurred in your life as a result of working with clients”. This change will allow the instructions on the TABS (Pearlman, 2003) and the PTGI-SF (Cann et al., 2010) to remain consistent across all administrations. In addition, these instructions are more in-line with the researchers theoretical framework and use of ecological momentary assessments.

Conclusion

The pilot study demonstrated that vicarious traumatization and posttraumatic growth could be observed in counselors in training and that further evaluation is needed. Future research on these constructs has the opportunity to provide information about how best to support, educate, and supervise counselors in training about the possibility of experiencing vicarious traumatization and posttraumatic growth as a result of working with clients. In this way, counselors in training will be forewarned, forearmed, and more prepared to enter and remain in the profession (Walker, 2004).